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I am submitting herewith a dissertation written by H. I. Paul Villas entitled "A Profile of Elder Abuse and Neglect in Tennessee." I have examined the final copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Education, with a major in Health Education.

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A PROFILE OF
ELDER ABUSE AND NEGLECT IN TENNESSEE

A Dissertation

Presented for the

Doctor of Education

Degree

The University of Tennessee, Knoxville

H. I. Paul Villas

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DEDICATION

This work is dedicated to my loving wife Sandra whose encouragement, hard work and support made this effort meaningful.

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ABSTRACT

The purpose of this study was to survey elder abuse cases reported to the Tennessee Department of Human Services and develop a profile of elder abuse for the state of Tennessee. This investigation looked at information compiled by the Tennessee Department of Human Services and used the Department's questionnaire on closed adult protective service cases as the instrument for data collection.

The study population consisted of 207 cases of reported abuse to individuals aged 60 and older. The investigation sought to determine demographic characteristics of the abused, perpetrators of elder abuse and neglect, types of abuse that occur and any existence of relationships in elder abuse and neglect between urban and rural counties and eastern and western counties.

The information supplied the investigator on computer diskette by the Tennessee Department of Human Services was deemed valid at the five percent level of significance by employing a validity and proportions test. Tests of central tendencies were used to analyze the data and

answer the research questions involved in the investigation.

It was found that the typical abused elder in Tennessee is a white female 76 years old who lives alone or with relatives and obtains most of her income from social security. However, when geographical considerations are taken into account, a black female has the same chance as a white female of being abused in western and urban counties. Neglect and self-neglect are the most common types of abuse and the elder victim is most often the perpetrator.

It is recommended that additional study be undertaken to further define neglect and to provide educational opportunities to learn more in areas of assessing, interviewing and reporting neglect.

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CHAPTER I

INTRODUCTION

As our aging population has continued to increase from three percent of the population in 1900 to a projected eleven percent by 1990, our long term care systems and family structure are recognizing and identifying the syndrome of elder abuse and neglect (Fulmer and Cahill, 1984). Although the problem is not new, there is recent evidence to suggest that elder abuse occurs at an alarming rate. The reported rate by Doyle and Morrow in their "Elder Abuse Awareness Project" (1985) was 500,000 to 2,500,000 cases of elder abuse, neglect or mistreatment per year, but only one in six cases were ever reported.

We tend to regard abuse and neglect of the elderly as a recent phenomenon in the western world, but that is not the case. Historians, sociologists and scientists have confirmed as purely myth that yesterday's family was a harmonious, generous and sympathetic multi-generational unit (Journal of the American Medical Association, 1987). European agriculturalists, merchants

and craftsmen arranged through contracts and legal documents that certain property rights be retained and their right in domestic influence be maintained on the transfer of property rights and assets to the next generation. These written guarantees and regulations lend credence to the idea that these older individuals had suspicion that their children might not accord them certain rights based merely on feelings of respect and benevolence (Rosenmayr, 1984).

A real problem associated with elder abuse is that it is difficult to quantify because both the victim and the perpetrator tend to downplay or deny its seriousness. Often, the victim is overwhelmed by the abusive situation and either is too embarassed to acknowledge that he or she is being abused and neglected or does not know where to turn to for help (Journal of the American Medical Association, 1987). Even though there are deficiencies in identification of elder abuse victims, abuse of some type or combination of types has been estimated to occur in approximately 1Ø percent of Americans over 65 years of age, and four percent of the victims may be of moderate to severe abuse (Clark, 1984).

Another problem is the broad parameters used for defining elder abuse and the many classification associated with abuse. Fulmer and Wetle (1986) state that "definitions of abuse vary widely, but generally include

physical abuse, psychological abuse, active neglect, misuse of drugs, misuse of property and violation of rights." In discussing elder abuse reporting laws and elder abuse legislation, the Beth Israel Hospital Elder Assessment Team (1986) mentions that these laws require the reporting of suspected abuse or neglect. The Council on Scientific Affairs of the American Medical Association lists published classifications of elder abuse as abuse, exploitation, neglect, self-neglect, violation of rights and medical abuse. The state of Tennessee's Adult Protection Act looks at abuse and neglect as synonymous since section 14-25-102 defines "abuse or neglect" to mean the same thing.

Fulmer, Street and Carr (1984) report that the lack of attention and reporting in relation to elder abuse is due in part to at least three factors. First, older people have only recently begun to make up a significant percentage of the population. Secondly, elderly abuse victims generally attempt to hide the facts of their situations from others. In the third place, the lack of awareness of elder abuse is simply one more example of "ageism" or the lack of concern for the rights and needs of the elderly in America.

The low reporting rates indicate that elder abuse is not being adequately dealt with and victims are not identified so that a safe environment can be provided

for them. Underreporting may be attributed to the inability to define elder abuse as well as the elderly person's fear of retribution from their care providers. Additionally, the elder's fear of institutionalization may outweigh their fear of abuse or neglect. Little is known about the unreported victim and although extrapolation from battered spouse studies and child abuse studies provide some information, the differences in the victims and their circumstances dictate that these insights cannot be applied with certainty (Fulmer, Street and Carr, 1984).

I. Purpose of the Study

The purpose of the study was to describe the types and extent of elder abuse and neglect of those individuals 60 years old and older from cases reported to the Tennessee Department of Human Services as a basis to develop a profile of the abused. The study also sought to provide baseline data to those responsible in screening, identifying and reporting elder abuse. In addition, the study sought to determine relationships in elder abuse between (1) urban and rural regions and (2) eastern and western regions.

II. Statement of the Problem

The literature reveals that inconsistency and lack of agreement exist in targeting and identifying potential victims of elder abuse and neglect. It is recognized that Tennessee does not have statewide profile information on the abuser nor the victims of elder abuse and neglect. In order to develop a statewide profile, answers to the following questions were sought:

1. What are the typical demographic characteristics of the abused?
2. Who is the perpetrator of the abuse?
3. What types of abuse occur?
4. What is the relationship in elder abuse between rural and urban counties?
5. What is the relationship in elder abuse between eastern and western counties?

III. Need for the Study

Recent awareness of neglect and violence directed at the elderly and recognition of elder abuse as a wide-spread problem has prompted federal, state and local response to this social injustice. Until the late 1970s, there had been little in the way of systematic documentation or public recognition of elder abuse (The Beth Israel Hospital Elder Assessment Team, 1986). The magnitude of the problem and the lack of a broad-based

data collection system by most states has hampered the identification and realization of the elder abuse and neglect condition.

The topic of elder abuse was opened by Walsh's (1977) paper on "granny bashing" in Great Britain and led to a series of studies in the United States. The Ohio Study provided a descriptive retrospective chart review of 404 cases (Lau and Kosberg, 1979). The Michigan Study interviewed 228 professionals in five community sites (Douglass, et al., 1980). The Maryland Study used a mailed survey of health care professionals in a selected community and the Massachusetts Study surveyed 1,044 professional and paraprofessional care providers (Block and Sinnott, 1979; O'Malley, et. al., 1979). All of the said studies gave us much needed information on elder abuse and neglect as well as providing impetus for protective legislation and reporting laws involving elder abuse.

The first laws requiring reporting for suspected cases of elder abuse, neglect, or mistreatment had their beginning in the guardianship and protective service programs of the early 1960s. Such programs were developed in order to meet the special needs of those elders who could not maintain basic living standards without some agency intervention. Through such programs, care providers and caseworkers became aware of the fact that some elders

were being abused or neglected and required more specific protection than had previously been offered.

Between 1974 and 1985, there were 41 states that passed elder abuse reporting laws for the protection of the elderly. In 1978, the Tennessee legislature enacted Chapter 25 -- The Tennessee Adult Protection Act. The Act seeks to protect adults from abuse, neglect or exploitation by requiring reporting of suspected cases by any person having cause to believe that such cases exist. The Act recognizes that adequate protection of adults will require the cooperation of many agencies and service providers in conjuction with the Department of Human Services. However, Tennessee does not have a mandated system for analyzing and gathering characteristic data of the abused elderly and those who inflict the abuse. Since there is a lack of available data analysis, the system does not allow aggregation and comparison of information concerning abused elders in Tennessee. Consequently, statewide documentation of types, extent and characteristic data of elder abuse and neglect is not fully and readily available. This study was conducted in an effort to meet the need of identifying parameters of elder abuse and neglect from reported cases to the Tennessee Department of Human Services.

IV. Delimitations

Certain delimitations that included the population, the state and the abusive situation were necessary to conduct the investigation and provide a profile of elder abuse in Tennessee.

The delimitations of this study were as follows:

1. The investigation was delimited to those individuals aged 60 or over in the state of Tennessee.
2. The investigation was delimited to those cases of elder abuse that involved situations which were reported to the Tennessee Department of Human Services.

V. Limitations

This study was concerned with providing broad-based information on elder abuse in order to target and identify potential victims of elder abuse and neglect in Tennessee.

The limitations of this study were as follows:

1. Any results or conclusions may be generalized only to those elders 60 years and older and to the state of Tennessee.
2. Because of the sensitivty and confidentiality of the information involved, the investigator did not have first hand availability of the reported cases.

VI. Basic Assumptions

The following assumptions were made in relation to the conduct of this study:

1. The data reported and collected by the Department of Human Services were accurate.
2. The methods of collecting and reporting data concerning elder abuse and neglect were consistent in all counties.
3. The reported cases were representative of the abuse and neglect of the elderly throughout Tennessee.

VII. Definition of Terms

The following definitions were employed in the study:

Abuse or Neglect: The infliction of physical pain, injury, or mental anguish, or the deprivation of services by the caregiver which are necessary to maintain the health and welfare of an adult, or a situation in which an adult, living alone, is unable to provide or obtain for himself the services which are necessary to maintain his health or welfare (Public Welfare Laws--State of Tennessee, 1986).

Abuser: An individual who actively or passively inflicts abuse on an elderly individual.

Active Neglect: Withholding of items necessary for daily living such as food, medicine, companionship and bathroom assistance.

Caregiver: An individual who has the responsibility of providing care to an elderly person. The caregiver could or could not be related to the elder individual.

Closed Cases: Resolved cases by the Tennessee Department of Human Services.

Department: The Tennessee Department of Human Services.

Elderly, Aged, Old: A person who is 60 years of age or older.

Emotional Abuse: Includes being verbally assaulted, insulted, humiliated, intimidated, threatened, isolated, ignored, frightened, or withholding of affection.

Elder Abuse: The term refers to and recognizes that there exists an abused victim and a perpetrator. Also, elder abuse recognizes that abuse has more than one classification.

Exploitation: The improper use by a caregiver of funds which have been paid by a government agency to an adult or to the caregiver for the use or care of the adult.

Mistreatment: Use of medications, isolation, or the use of physical or chemical restraints that harm or

are likely to harm the person (Fulmer, Street and Carr, 1984).

Passive Neglect: Characterizing situation in which the elderly person was left alone, isolated or forgotten (Hickey and Douglass, 1981).

Physical Abuse: Corporal punishment or injury, beatings, sexual assault, constraints and deprivation of food or water (Thobaben and Anderson, 1985).

Self-Neglect: Lack of personal attention in matters of medication, hygiene, food, water and other basic needs resulting from depression, dementia, psychoneurotic reactions and illness.

VIII. Summary

The U.S. House of Representatives Select Committee on Aging (1980) called elder abuse "alien to the American ideal" and "a shameful and hidden problem." The situation is compounded and continues to exist because there is not a broad-based targeting, identifying and reporting system. This investigation sought to address the said problem by providing a profile of elder abuse and neglect for the state of Tennessee. This profile will provide data analysis and allow for aggregation, documentation of types, extent, characteristics, and comparisons of elder abuse information throughout the state.

IX. Organization of the Study

Chapter I contains the statement of the problem, statement of the purpose, research questions, need for the study, delimitations, limitations, basic assumptions and definition of terms. Chapter II consists of the review of the related literature. Chapter III presents the methodology, the subjects for the study and the instrument utilized for data gathering. Chapter IV is an analysis of the data in relation to the research questions. Chapter V includes a summary, conclusions, recommendations and implications for further study and Chapter VI contains additional thoughts the investigator has on the Tennessee Department of Human Services, the instrument and the findings of the study.

CHAPTER II

REVIEW OF RELATED LITERATURE

In the review of the literature, information is presented in the following catagories: (1) Definitions of elder abuse; (2) Incidence and prevalence of elder abuse; (3) Factors connected with elder abuse; (4) Intervention in elder abuse; (5) Assessment of elder abuse; and (6) A summary.

I. Definitions of Elder Abuse

Any type of abuse can parallel Hans Christian Andersen's fairy tale of The Emperor's New Clothes. The Emperor's lust for new clothes allowed him to hire two swindling tailors to weave for him some new clothes. The weavers boasted that only those fit for office could see these exquisite clothes. After sending his ministers before him to examine the progress of the weavers, the Emperor could see nothing and, like them, was afraid to admit it lest he admit he was not fit for his own post. Because everyone in the town, from the Emperor on down,

would not admit to what their eyes were seeing, they went on fooling themselves and each other and did not accept the obvious. As it turned out, the Emperor, for a parade, put on his new clothes which were no clothes at all. Everyone pretended he was clothed in fine attire and refused to admit the truth until a child spoke up and said, "He has nothing on. He is naked!" Like the Emperor's naked body, abuse must also be exposed and admitted before anything can be done about it.

Child abuse was exposed in the 196Øs; wife abuse was exposed in the 197Øs; now in the 198Øs, elder abuse has become a topic of concern (Pedrick-Cornell and Gelles, 1982; Douglass, 1983). Piece by piece, article by article, the ugly body of abuse is being clothed as more and more is learned about patterns of family violence. It is against the background of increased research on family violence, demographic changes in society and a concern for the problems of our older people that elder abuse has become a topic of interest (Pedrick-Cornell and Gelles, 1982).

Violence is America's sweetheart, but the elderly are not, and they pay a heavy price as victims of societal neglect and blatant discrimination. Family life which reflects the norms and values of society continues to be characterized by violence. None of the variations in today's family structure and living arrangements seem to be protected against it, and now there is much evidence that

the elderly are the next category of hidden victims of intrafamily violence (Rathbone-McCuan and Voyles, 1982).

As we try to find answers and develop a knowledge base on elder abuse, the dilemma that faces students and researchers is agreeing on a definition. The literature parallels a similar path in elder abuse to that of child abuse and spouse abuse in groping for a definition. Areas of similarities in all abuse have been intentionally active vs. passive neglect, outcome, physical vs. non-physical mistreatment, acts of commission vs. acts of omission, and others. The lack of a clean and comprehensive definition of elder abuse is a big obstacle in rallying more action around this issue. Not having a good definition makes it difficult for practioners, laymen and researchers to bridge the gap of all their perceptions and experiences in order to help those in need--the elderly (Bookin and Dunkle, 1985).

Some researchers confine the definition of elder abuse to physical abuse of non-institutionalized elderly; others include verbal or emotional abuse and make a distinction between passive and active neglect (Rathbone-McCuan, 1980; Douglass, Hickey and Noel, 1980). Block and Sinnott (1979) include in their definition mental abuse as well as and as distinct from physical abuse. Lau and Kosberg (1979) include in their definition a violation of rights by informal caretakers. Mistreatment due to

stress on the caregivers part was also mentioned (O'Malley, Segars, Perez, Mitchell, and Kneupfel, 1979). It should be noted that the definitions in the cited studies came from responses by professionals, paraprofessionals and investigators in the areas of adult protective services or rendering service. Rathbone-McCuan's (1980) study was an investigation of emergency room patients in St. Louis, Missouri; Douglass, Hickey, and Noel's (1980) study included personal interviews with practioners and professionals in Michigan; Lau and Kosberg's (1979) study in Cleveland, Ohio, was a review of records at the Cleveland Chronic Illness Center; Block and Sinnott's (1979) study involved mailing questionnaires to direct service personnel throughout Massachusettes. "Research which samples only from those cases that come to official attention is research which cannot partial out the factors which lead to a case being labeled from factors which caused the person to be abused" (Pedrick-Cornell and Gelles, 1982).

In an effort to partial out factors, Garbarino and Gilliam (1980) offer two important criteria to use as guidelines in developing a definition--effect and standards. The definition should focus on the effect abuse has on the elderly instead of in terms of behavior. This focuses intervention on harm done to the elder and away from the many cultural biases about appropriateness of

certain behaviors within a family (Boodkin and Dunkle, 1985). Two kinds of standards can be used to define abuse--community standards and professional knowledge. Community standards are those that a community regards as appropriate treatment of its elderly. Professional knowledge (medical, psychological and gerontological) will allow us to determine what conditions and situations are nuturing, harmful or inappropriate for the elderly (Bookin and Dunkle, 1985). Only as we continue to explore and measure the data available and that to come can we facilitate a more comfortable and accurate definition. Hopefully, we can arrive at a definition that has rooted out cultural biases, differences in accessibility and experience of practioners.

II. Incidence and Prevalence of Elder Abuse

In the past decade, there has been an increased awareness of the incidence of domestic violence (Bernard and Bernard, 1983). Society as a whole will tend to evaluate this violence on how harmful situations are to a significant number of people. There is no argument that the abuse of the elderly is harmful, but for society to act, there needs to be documentation that the incidence of elderly abuse includes a significant portion of our population. So, like child abuse and spouse abuse, the

questions that need an answer are "How prevalent is elder abuse?" and "What is the incident rate?"

Some data suggests that the incidence and prevalence of elder abuse occurs with a rate and frequency only slightly less than child abuse (U.S. Congress, House Select Committee on Aging, Elder Abuse, 1981). Child abuse is found in one out of every two homes. Spouse abuse occurs in one out of every six households in any given year (Bernard and Bernard, 1983). Block (1980) extrapolates from child abuse data that elder abuse may be as common.

Rathbone-McCuan's (1980) investigation of elderly emergency room patients in St. Louis, Missouri, found the elderly patients studied were beaten, exploited, and/or neglected by people upon whom they depended. Lau and Kosberg (1979) reviewed 404 records of elderly patients of the Cleveland Chronic Illness Center in Cleveland, Ohio, to determine if they had been victims of neglect or abuse before their admission. They concluded that 39 out of 404 clients had been neglected or abused before their admission to the Center. They estimate that one in 10 elderly persons that are dependent on someone is abused each year.

Block and Sinnott's (1979) mail survey in Maryland to members of the Gerontological Society of America, the American Psychological Association and the College of Emergency Physicians received a 31% response. They concluded that 13.4% of their respondents (4.2% of the

sample) reported at least one case of neglect, abuse or financial exploitation. They speculate that the prevalence of neglect or abuse of the elderly may be greater because 88% of their respondents indicated they had heard of a problem or a case of elder abuse in the six months preceeding the survey. Only 12% had never heard of any abuse and the prevalent type of mistreatment was psychological abuse.

O'Malley, Segars, Perez, Mitchell, and Kneupfel (1979) used a questionnaire to sample direct service personnel on how much they knew about abuse and neglect of the elderly in Massachusetts. The personnel included social workers, police, private agency staff, nurses, and legal service workers. There were 332 questionnaires returned for analysis (a 34% response rate). They identified the victims of abuse as the older elderly person, frail, mentally or physically handicapped, female and living with the person responsible for their abuse or neglect. Also, 63% of the respondents knew of at least one case of elderly abuse in the previous year and a half.

In Michigan, Douglass, Hickey and Noel (1980) conducted personal interviews with health and social practitioners and professionals to determine what if any experience they had had with mistreatment and abuse of the elderly. They included 228 interviews in their analysis. The study found that those surveyed found little to no

direct contact with verbal or emotional abuse, active neglect or physical abuse, while 50% reported contact with passive neglect. The group consisted of police officers, physicians, nurses, social workers, mental health workers, lawyers, clergy, morticians, coroners and medical examiners. The statistics that we currently and frequently see cited put the range of elder abuse cases between 500,000 and 2,500,000 per year. This information is supplied by the Senate and House of Representatives Special Report (1980). The senior Congressman from Florida, Claude Pepper, calls this a "tragic consequence for older Americans" (Fulmer and Cahill, 1984).

In Oklahoma, for his doctoral work, Galbraith (1984) studied individuals 60 years and over who reported cases of abuse to the 13 agencies in the Oklahoma Coalition on Domestic Violence and Sexual Assault. The reported cases examined were for the years 1981 and 1982. His purpose was to develop a profile of elder abuse in Oklahoma. Galbraith (1984) used two questionnaires as data collection instruments. The first was a closed-form questionnaire developed from the Coalition`s "shelter intake" form and the Oklahoma Department of Mental Health "Intake and Follow-up Abstract." His second instrument was a telephone interview questionnaire that was used to gather perceptual information from the directors of the Coalition agencies. His findings included that there is a lack of a

broad-based collection system due to the fact that agencies and state departments which are responsible for the abused elderly are not mandated to gather and analyze characteristic data. He found that women have a higher risk of being abused than men and the perpetrator is likely to be a spouse, son or other relative living in the same household. Other findings were that the abuser was a near-elderly or elderly person; elders are subjected to more than one form of abuse in which physical abuse is combined with another type of abuse; and elder abuse is a recurrent problem in that those who report abuse have been abused before.

It needs to be noted that despite all the information we have on elder abuse in regards to incidence and prevalence, there is still much we do not know. The problems and limitations of the reports cited are created because they are based on cases which are reported to human and social service agencies (Pedrick-Cornell and Gelles, 1982). Because of the nature of the agencies and the fact that we do not have uniform laws in all states, it is reasonable to assume that current data is not representative of all the elderly. To complicate matters more, we have to allow for the cases that are not reported. Ann Langley (1981) acknowledges that the older abuse victim rarely reports abuse. The reasons for underreporting elder abuse may be due to the various problems surrounding its

detection. Sometimes symptoms of elder abuse and neglect are mistaken for symptoms of normal aging. Fractures, discoloration, pressure areas, dislocations or hypothermia may be the natural result of decreased circulation, osteoporosis, or capillary fragility, but on the other hand, it could signal abuse or neglect (Sengstock and Liang, 1982). Health professionals and people in general will tend not to report elder abuse for fear of falsely accusing the family and invading their privacy (Mildenberger and Wessman, 1986). Other reasons may be public unawareness along with the problem of not having a clear, precise definition. Many workers in social services and health care agencies are naive to elder abuse, and others believe that domestic violence is a private, personal matter that should not be addressed by outsiders (Sengstock and Liang, 1982). In many situations, we will never know the extent and frequency of abuse these silent victims suffer.

III. Factors Connected With Elder Abuse

Major demographical changes have occured in this country in the last half century which may help explain some of the problems we are encountering today with elder abuse. First, the life expectancy has risen dramatically to 75 years in this century (A Profile of Older Americans, 1986). Second, in contrast to 1900 when

one in 11 Americans was 65 or older, today it is one in eight and by the year 2000, one in six Americans will be 65 years of age or older (U. S. Bureau of the Census, 1986). The aging of the population has resulted in an increased need for long-term care of the elderly. One person in 50 between the ages of 65 and 72 years of age needs long-term care. But of those over 73 years of age, the chances increase to one in 15 (Kock and Kock, 1980).

To unravel the causes of a very intricate problem such as elder abuse is to identify the major social and psychological factors associated with being abused and being an abuser. No one programs himself or herself into these categories, so we must conclude that there are many and various situations and factors that lead a person to fall in the category of abuser or abused. The literature offers some answers and insights into the profile of the abuser, the abused and the abusive situation.

Victim Profile

A typical abused elder is likely to be Protestant, middle class, female, over age 65 years, white, frail, mentally or physically impaired, highly dependent on others for her daily needs and living with relatives (O'Malley, Everitt, O'Malley, and Campion, 1983; Rathbone-McCuan, 1980). She has also been described as

80 to 84 years of age who has lived with a family member for 10 or more years (Ghent, DaSylva and Farren, 1985) and as a causasian female, 70 years or older, with moderate to severe physical or mental impairment (Select Committee on Aging, House of Representatives, 1981). The abused elder is often a source of stress to the abuser and the elder is usually unaware of alternative living arrangements or means of support (O'Malley, Everitt, O'Malley and Campion, 1983; Mildenberger and Wessman, 1986). In our current society where the elder relative may have to be brought into the nuclear family, the elder person may be looked upon as nonproductive and roleless, being a burden rather than a contributor (Johnson, 1979).

Other literature says that the elderly victims of abuse are unlikely to seek help because of isolation, shame, feelings of powerlessness, or fear of reprisals. In both the Michigan (1980) and the Maryland (1979) studies, either the victim or the abuser in the majority of the cases had sought help but were unsuccessful.

Abuser Profile

Those who abuse the elderly are most often family members whereas the caretaker who is not related is least likely to be abusive (Mildenberger and Wessman, 1986). In all types of abuse and neglect, daughters and sons were found to abuse most frequently followed by the

spouse, grandchildren, siblings, nieces and nephews, and cousins (Doyle and Morrow, 1985). A Canadian study found that the son was the most likely abuser, followed by the daughter and then the spouse (Ghent, DaSylva and Farren, 1985). The Select Committee on Aging, House of Representatives (1981), says that the abuser is commonly a relative living with the elderly victim and Lau and Kosberg (1979) report that the abuser is thought to be the middle aged daughter of the victim. Daughters are involved more frequently in psychological abuse and forms of neglect, both psychological and physical. Adult sons are more involved in physical abuse and assault (Mildenberger and Wessman, 1986).

Service providers have indicated some possible causes. In the case of neglect, it seems to be a matter of apathy or ignorance. In more serious cases, the providers felt that it is a generation conflict since the middle generation may be meeting the needs and demands of their children and older family members at the same time (Doyle and Morrow, 1985). The majority of abusers suffer from some form of stress, drug addiction, alcoholism, or chronic medical or financial problems (O'Malley, Everitt, O'Malley and Campion, 1983; Rathbone-McCuan and Voyles, 1982). A person under great stress might be more capable of neglecting or abusing the older person if alcohol abuse was also present (Doyle and Morrow, 1985).

Abusers may fear losing control either of their own emotions or of the ability to control the distribution of power and resources between the aged person and the abuser's personal needs. Some abusers admit druging their parents in order to keep the parent and his/her affairs under control (Rathbone-McCuan and Voyles, 1982).

Theories on Abuse and Neglect

No single answer or explanation can be given as to why elder abuse occurs. Numerous theories have been suggested that may or may not overlap. Sengstock and Liang (1982) have developed three basic models of causation: the psychopathological model, the learning model and the situational stress model. Of the three, the psychopathological model is probably the most frequently proposed explanation of domestic abuse.

The psychopathological model emphasizes the psychological problems of the abuser. Drug and alcohol abuse are a frequent cause of maltreatment (Sengstock and Liang, 1982). Providers often express the concern that alcohol may frequently be the precipitating factor (Doyle and Morrow, 1985). The abuser may actually be mentally ill or suffering from emotional or psychiatric problems that result in violent sociopathic behavior directed against the elderly family member (Sengstock and Liang, 1982).

The learning model says that abusive adults were abused as children (Hickey and Douglass, 1981). In some families, domestic violence is a learned behavior when the parental role model is abusive. Once the abused child reaches adulthood, the resource power balance shifts to the offspring and he may seek revenge for enduring all that suffering as a child by abusing his parents (Sengstock and Liang, 1982).

The situation stress model may be the one understood by most people. The overwhelming duties and responsibilities that are associated with providing care for the elderly parent may place undue demand on the adult caregiver. The adult child has to change and modify his previous lifestyle including entertainment and recreation as well as social relationships and may change or modify his job to be at home to care for his elderly parent (Steuer and Austin, 1980). Other stress factors may include lack of finances to provide proper care, inadequate housing or overcrowding, lack of support from other family members, physical problems or illness of the adult child, and a lack of awareness that there are services available to help cope with these stressors (Douglass, 1983). Also causing stress are "generational" pressures in which middle aged caretakers are caught between their personal retirement and advancing age, the financial pressures of their children with college or

marriage, and the demands and finances of caring for the elderly parent (Journal of the American Medical Association, 1980).

Further support for the stress model comes from data gathered from a study by Sengstock, Barrett and Graham (1984) in the greater Detroit area. Their findings were that families of elder abuse victims have been beset by a large number of problems in a short period of time. Further, it seems that most of the abuse victims in their study define their most serious problems in terms other than the direct abuse observed. They summize that the problem of elder abuse is just a segment of a much broader picture. The problem requires more than just blaming the offender, they say, because both the offender and the victim are caught in a web of personal family problems from which they see no opportunity for escape.

Another theory mentioned by Sengstock and Liang (1982) suggests that the elder may cause the abuse by provoking or tempting the abuser to strike out. The problem seems to be that the aged parent tries to retain the same control over his or her children that he had when they were at home and does not realize that the power balance is different. There is even mutual abuse between family members. In this vicious cycle, family members alternately reinforce the abusive behavior of one another (Rathbone-McCuan, 1980).

It is reported in children's literature that child abuse occurs more frequently to those children that are mentally or physically handicapped (Fredrick and Boriskin, 1976). Researchers in elder abuse find a similar pattern. They agree that older persons with physical or mental handicaps run a greater risk of being abused than do those of similar circumstances but having no physical or mental impairments (Block and Sinnott, 1979; Rathbone-McCuan, 1980).

O'Malley, Everitt, O'Malley and Campion (1983) have come up with a fourfold theoretical hypothesis for the cause of elder abuse. They make their point by saying that the pathological nature of the caregiver must be emphasized along with the dependency of the elder victim as a potentially powerful trigger, the stresses of caring for the impaired elderly, and a look for a pattern of transgenerational violence. It is believed that the use of violence to resolve conflicts runs in families, and this use of violence is passed on from generation to generation (Rathbone-McCuan, 1980; Steinmetz, 1978).

Pedrick-Cornell and Gelles (1982) believe that there are many drawbacks in the current literature. They cite, for example, that the abused elderly suffering from mental and physical impairments could simply be a function of the fact that agencies caring for the elderly have many patients who are mentally or physically

handicapped. Concerning stress, they argue that current literature cannot answer the question "Is the stress found in homes where there is elder abuse greater than stress found in homes of similarly aged elderly who are not abused?" Another question they feel needs attention is, "Is the agency in which the research data has been gathered seeing a disproportionately large population of very old individuals?" They emphasize that we have not had comparison groups in our studies and until we do, it will be impossible to establish statistical significance of relationships or magnitude of associations. Empirical testing and empirical data is what they want generated. Although the propositions presented are plausible, there may also be many other plausible rival explanations for elder abuse.

IV. Detection and Intervention in Elder Abuse

Those interested in child abuse give Kempe and his colleagues credit for bringing it to the the attention of the public (Kempe, Silverman, Steele, Droegemueller, Ward, Silver, 1962). It was more than a decade after their report until the first National Conference on Child Abuse was held in Washington, D.C., in 1973. Before 1973, there was little scientific information on wife abuse. However, from the "discovery" of wife abuse, it took about three years for media coverage and

Congressional hearings. The time frame is even shorter from the "discovery" of elderly abused and the media attention and local, state, and federal legislative initiatives (Pedrick-Cornell and Geddes, 1982). While there may be disagreements on demographics and definitions of elder abuse, we do not have enough of a working base to mobolize for action. Our problem may come in knowing exactly what action to take. It may well be that our interest and concern about elder abuse has outpaced good scientific evidence from intervention. Yet there have been those that have proposed ideas and guidelines for intervention in elder abuse. Their methods and propositions should not be discounted, however, but should be used as impetus for present intervention and future research. Although the present knowledge base relies heavily on data supplied by human service professionals, it has failed to address the unique problems and dilemmas faced by those who must intervene in such situations. Workers who are assigned to cases of elder abuse have difficulties not only related to the nature of the problems but also to their own personal feelings, biases, and attitudes about violence and the aging family (Bookin and Dunkle, 1985). Getzel (1981) reports that social service professionals are rarely used by caregivers and goes on the say that one reason may be the ineffectiveness of social work.

Since the overall purpose of intervention is to help the abused elder, the best possible time to intervene would be before the abuse takes place (O'Malley, Everitt, O'Malley and Campion, 1983). But before we can intervene, two major barriers must be overcome. First is the denial by professionals that the problem exists and that its prevalence may be increasing. Second is the lack of procedures for case detection (Rathbone-McCuan and Voyles, 1982). Other studies have shown that neglect of the elderly is viewed by professionals as not only benign in its effects, but as a somewhat "normal" phenomenon in our society. Isolation and loneliness of the elderly did not seem to be as great a concern to professionals and practitioners as the many other social and human problems they face. Professionals have come to accept the societal stereotype of old age as a negative period of disengagement and anonymity (Hickey and Douglass, 1981).

Intervention could include family counseling at the time the aged parent moves into the adult child's home, training in the care of elder persons, and the use of community support services. Community services include day care, financial aid, respite care, "meals on wheels", home nursing services, elder sitters, and accessible transportation (Douglass, 1983; Journal of the American Medical Association, 1980). These services allow the caregiver time off from the pressures and strain of

providing care and hopefully prevent the occurence of situations that might lead to abuse (Sengstock and Liang, 1982).

Those providing health care need to familiarize themselves with the signs and symptoms of abuse as well as reporting laws. Knowing the correct agencies to contact is important. As with other types of abuse, mandatory reporting seems to be a reasonable way of protecting individual rights and still encourage those who see cases of elder abuse to seek help. The success of child abuse has been the mandatory reporting requirement of its occurrance. Elder abuse reporting has been modeled after the child abuse laws but there needs to be an awareness that these abuses are not equal. The independent, competent, adult status of most victims of elderly abuse contrasts with that of a minority status of the child. So much thought must go into any law or laws intended to protect ther elderly and also to insure that their rights are not compromised by wellmeaning law makers. In larger cities, one might contact an adult protective services division of the social service agency. In more rural areas, the county or city law enforcement service may be the proper agency to contact (Johnson, 1981). Legal action should be the last resort of intervention (Steuer and Austin, 1980).

The current key problem is that of a uniform approach to elder abuse (Mildenberger and Wessman, 1986). There is inconsistency in state codes. Prosecution of caretakers for assault and battery, or even for imprisonment, can be granted in some states. The problem arises when the abused elder refuses to prosecute. Consequently, the investigation is unlikely and evidence is difficult to gather (Steuer and Austin, 1980).

The topic of elder abuse and neglect needs and demands heightened public awareness, further investigation, and standardization of classification and intervention procedures. Caregivers, as with many social and health care issues, are in a unique position to address these concerns as identifiers, interveners, and friends for the elderly patients (Mildenberger and Wessman, 1986).

James Callahan (1982) raises a question asking to what extent should our definitions of a policy problem be limited by out capacity to respond to it. He further states that a legalistic approach to a problem can be contrasted to a behavioral approach that assumes saying so does not result in doing so. Passing a law will not solve elder abuse. Callahan (1982) quotes the British lawmaker Alvin Toffler's book The New Wave in which he says:

> "We've solved every problem with legislation. . . We've passed seven acts against inflation. We've eliminated injustice numerous times. We've solved the ecology problem. Every

> problem has been solved countless times by legislation. But the problem remains. Legislation doesn't work" (Toffler, 1980).

Callahan does not believe intervention works. He states it is temporary and the problem will reconstitute itself. As a strategy for public policy on elder abuse, Callahan (1982) and Hooyman, Rathbone-McCuan and Klingbeil (1982) recommend:

1. Recognition of the changing age structure of the society with more private and public funds being invested in needs of the elderly. Private consumption patterns will need to change as well as public appropriations.
2. Lodging the protective function for all family abuse (child, adult, elder) in a single public agency that has the mandate and the skilled staff required. Actual intervention should always be the responsibility of public agency staff, not contractees. Necessary service based on a plan of care can be delivered by public agency staff or contracted for with providers.
3. Maintenance of a separate network for elders, such as the councils on aging, senior centers and home care corporations coordinated with other social service programs. The rationale for this is that these are access

points that have been successful in attracting and serving older persons.

The greatest abuse that can beset our elders is failure to provide them with the economic means for a decent life and opportunities to exercise their own choices. Insuring the economic health of the elderly will go a long way in improving health, housing and family relationships (Callahan, 1982).

V. Assessing Elder Abuse

Values in Assessment

Linda Phillips (1983) in her study of the abuse and neglect of the frail elderly at home found that there were significant differences between the two groups she studied in the area of religiosity and values. Her population consisted of 74 elderly subjects. They were divided into two groups--those who had good relations with their care givers (N-44) and those that were abused (N-30). The subjects in the good relationship group reported being more religious than did members of the abuse group and the responses of the subjects in the abuse group had binodal distribution. Block and Sinnott (1979) also found that religious preference may have a significant influence in the abuse of the elderly. Violent interactions in our society generally involve

direct coercive force by those in a superior status group toward those of lower status (Steinmetz and Strass, 1974). Positive values and understanding could alter this superiority notion.

It appears that those persons with a religious background are influenced in their decision-making and value judgments by their "spiritual culture." Therefore, if in assessing, defining or intervening in elder abuse, we rely on our background and value system to make those judgments, it would be safe to conclude that our previous experience and cultural bias are prime movers in decisions we make.

We have different perceptions and a variety of ways of defining and looking at violence (Podnieks, 1985). Podnieks (1985) cites an example of a social worker and her supervisor not being able to agree on whether a particular case was an abusive situation (the caregiver hitting the elder with a hairbrush in order to control her). The situation became much clearer to the supervisor when at the agency's annual family outing, the worker physically disciplined her own child in public. The supervisor realized that she and her worker had two different notions as to the use of force. The lesson is clear--we assess and define based on our background.

Reporting the Assessment

When it comes to protecting abused elders and determining what legal responsibilities caregivers have, each state has its own legislation; there is no federal policy (Thobaben and Anderson, 1985). Nurse practitioners and other care providers are mandated by law to report elder abuse if there is reasonable cause to suspect there has been mistreatment, abuse or neglect. Patient well-being as well as legal liability provide strong incentives to become more familiar with high-risk signs and symptoms of abuse as well as reporting laws which govern practice (Fulmer and Wetle, 1986).

From March, 1983, to February, 1985, in their study of states that have mandatory reporting laws, Thobaben and Anderson (1985) found that four states (Colorado, Iowa, Wisconsin and Wyoming) have a voluntary reporting law and nine states (Indiana, Kansas, Maryland, Mississippi, New Jersey, New York, North Dakota, Pennsylvania and South Dakota) have no mandatory reporting laws. Their review of state laws reveals that 17 states have reporting laws which specifically cover elders, 21 states include the elderly under disabled adult laws and four states have voluntary reporting laws.

A study conducted by Salend, Kane, Satz and Pymoos (1984) comparing elder abuse experting statues found that they varied widely in purpose, coverage, implementing agencies, registry requirements, mandating reporters and reporting requirements, immunity provisions, confidentiality provisions and mandating investigation or service components. The statues have not insured consistent information about elder abuse within or across states. They found that one of the areas of abuse most frequently reported was neglect and with the neglect category, self-neglect is predominate.

Tools for Assessment

As local, state and federal agencies are becoming more aware of elder abuse as a serious problem for the aged, they also need to be able to provide assistance and guidance for those in a position to assess this problem. The need is apparent for a concise, empirical assessment instrument that targets potential victims of elder abuse and that can be used readily by care providers (Fulmer and Cahill, 1984).

Because of the perceived need, Fulmer and Cahill (1984) undertook a study to develop such an instrument. The instrument they developed was The Elder Assessment Protocol (TEAP) whose designed purpose was to elicit

data on those variables that research has shown to be related to symptoms of elder abuse. The instrument consisted of nine general sections: demographic information, general assessment, physical assessment, usual lifestyle, social assessment, medication assessment, summary, disposition and general comments. Each section listed items appropriate to the general heading and provided five response options in a Likert Scale format. The testing of the instrument (TEAP) occured at the emergency room of the Beth Israel Hospital in Boston, Massachusetts. The testing provided helpful profiles of the elderly who might come to an emergency room for treatment and it formed a baseline against which the nurse can compare those elderly who are suspected of abuse or neglect.

Earlier, Terry Fulmer (1984) developed the Elder Assessment Tool (EAT), a forerunner to The Elder Assessment Protocol. The name of The Elder Assessment Protocol was later changed to the Elder Assessment Instrument (EAI). The EAI was developed over a four-year period at Boston's Beth Israel Hospital and provides a comprehensive approach for screening suspected elder abuse victims (Fulmer, Street and Carr, 1984). This instrument has been determined to be valid and reliable for assessing elder abuse and provides a simple checklist format with space for

comment when assessing elder abuse (Fulmer and Wetle, 1986).

The EAI includes categories that are mandated to be reported--areas such as physical abuse, neglect, mental anguish and exploitation. It also provides assessment parameters which help those evaluating determine the level of the elder's dependence. The summary assessment provides a place for the assessor to document the degree of evidence available for the documentation of abuse. Space is provided for follow-up and evaluation (Fulmer and Wetle, 1986).

VI. Summary

The literature reviewed for this investigation indicates that elder abuse has become a topic of concern in the 1980's just as spouse abuse was in the 1970's and child abuse in the 1960's. As interest in elder abuse has grown, so has the problem of attaining an agreeable definition. In defining elder abuse, all researchers include physical abuse. Variables such as verbal or emotional abuse, active and passive neglect and rights violations are areas included by others.

The incidence and prevalence of elder abuse may be as common as child abuse and estimates are than one in 10 elderly persons that are dependent on someone else is abused yearly. Five major studies reviewed from

Ohio, Missouri, Maryland, Michigan and Massachusettes revealed that elder abuse is definitely a problem. These studies found that the elderly were neglected and/or exploited by the people upon whom they depended; the vast majority of health professionals were familiar with cases of elder abuse; social service personnel are aware of elder abuse and report that victims of abuse are older elderly persons, frail, mentally or physically handicapped, female and living with the person responsible for their abuse or neglect; passive neglect is a big problem and elder abuse cases total between one half million to 2,500,000 per year.

Factors connected with elder abuse may include the mobility of today's population, the fact that life expectancy has risen dramatically and thus the need for long-term health case of the elderly. The literature describes the typical abused elder as Protestant, middle class, female, over 65 years old, white, frail, mentally or physically impaired, dependent on others, living with relatives and a source of stress to the abusive party. The elder victim is usually unaware of alternative living arrangements and looked upon as nonproductive and roleless. Daughters and sons of victims are most often responsible for the abuse and neglect and the perpetrators tend to suffer from

stress, drug addiction, alcoholism or chronic medical or financial problems.

Numerous theories on why abuse and neglect occur have been suggested that may or may not overlap. Three basic models include the psychopathological model which emphasizes the psychological problems of the abuser; the learning model which says that abusive adults were themselves abused as children, and the situation stress model which is described by the overwhelming duties and responsibilities that are associated with providing care for the elderly and place undue demands on the caregiver.

As mobilization to confront elder abuse has gained momentum, a situation that has not received much attention is the unique problem and dilemma faced by those who must intervene in abusive and neglectful situations. The personal feelings, biases and attitudes about aging involving personnel who must work with elderly are definitely intervention problems. Since the purpose of intervention is to help the elderly, the best possible time to intervene is before the abuse or neglect takes place. But before intervention can take place, barriers of denial by professionals that the problem exists and the lack of procedures for case detection must be dealt with and resolved.

Those responsible to provide care for elder patients are mandated by law to report suspected abuse, and it is in their best interest to become more familiar with high-risk signs and symptoms of abuse as well as reporting laws which govern practice. In every law, the nurse is either named specifically as a reporter or included with others in terms such as "health professionals," "practitioners of healing arts" or "any person with knowledge of, or who reasonably suspects, abuse." The people providing health care need not only attain skills for clinical assessment, but also in elder-abuse assessment once an awareness of the problem exists.

Because there are broad parameters for defining elder abuse, caregivers need to be familiar with those definitions and reporting policies that cover their geographic areas of practices. Although definitions vary widely, they generally include physical abuse, psychological abuse, active neglect, misuse of drugs, misuse of property and violation of rights.

The state of Tennessee includes protection of the elderly with that of disabled adults 18 years or age and older. The protection covers physical mistreatment, mental anguish, neglect, exploitation, and other abuse that would fall in these categories. The abuse is to be reported immediately and investigation is to start as

soon as possible. Consent from the abused elder is required for services to be rendered.

CHAPTER III

METHODOLOGY

This chapter explains the procedures utilized to describe the types and extent of reported abuse and neglect of elders and to present a profile of elder abuse in Tennessee. The chapter describes the subjects for the study, the instrument utilized, and the procedures used in gathering data as well as the research design, data tabulation and statistical analysis.

I. Subjects for the Study

The subjects for this study were individuals 60 years and older who lived in the state of Tennessee and who reported cases of abuse to the 12 agencies of the Department of Human Services. Although the Tennessee Department of Human Services is ultimately responsible for enforcing the "Tennessee Adult Protection Act" of 1978 and its subsequent amendments, the agency which carries out the actual duties is the Adult Protective Services. The agencies receiving information on the

subjects for the study were the regional Adult Protective Services who in turn report their findings to the state program director for Adult Protective Services. The reported cases examined were terminated during the month of April, 1987.

II. Instrumentation

The instrument used for this study was the Tennessee Department of Human Services Questionnaire on Closed Adult Protective Services Cases (see Appendix A). The instrument was developed as a result of the 1978 Chapter 25 Adult Protection Act enacted into law by the Tennessee Legislature. Section 14-25-103(C) of the law states that

> An oral or written report shall be made immediately to the department upon knowledge of the occurance of suspected abuse, neglect, or exploitation of an adult. Any person making such a report shall provide the following information, if known: the name and address of the adult, or of any other person responsible for his care; the age of the adult; the nature and extent of the abuse neglect or exploitation including any evidence of previous abuse, neglect, or exploitation; the identity of the perpetrator, if known; the identity of the complaintant, if possible; and

any other information that the person believes might be helpful in establishing the cause of abuse, neglect and exploitation.

The instrument was designed to comply with section 14-25-103(C) of the Adult Protection Act in that it fulfills the requirement of a written report being submitted of any suspected abuse, neglect or exploitation. The Department of Human Services deems the instrument valid and reliable.

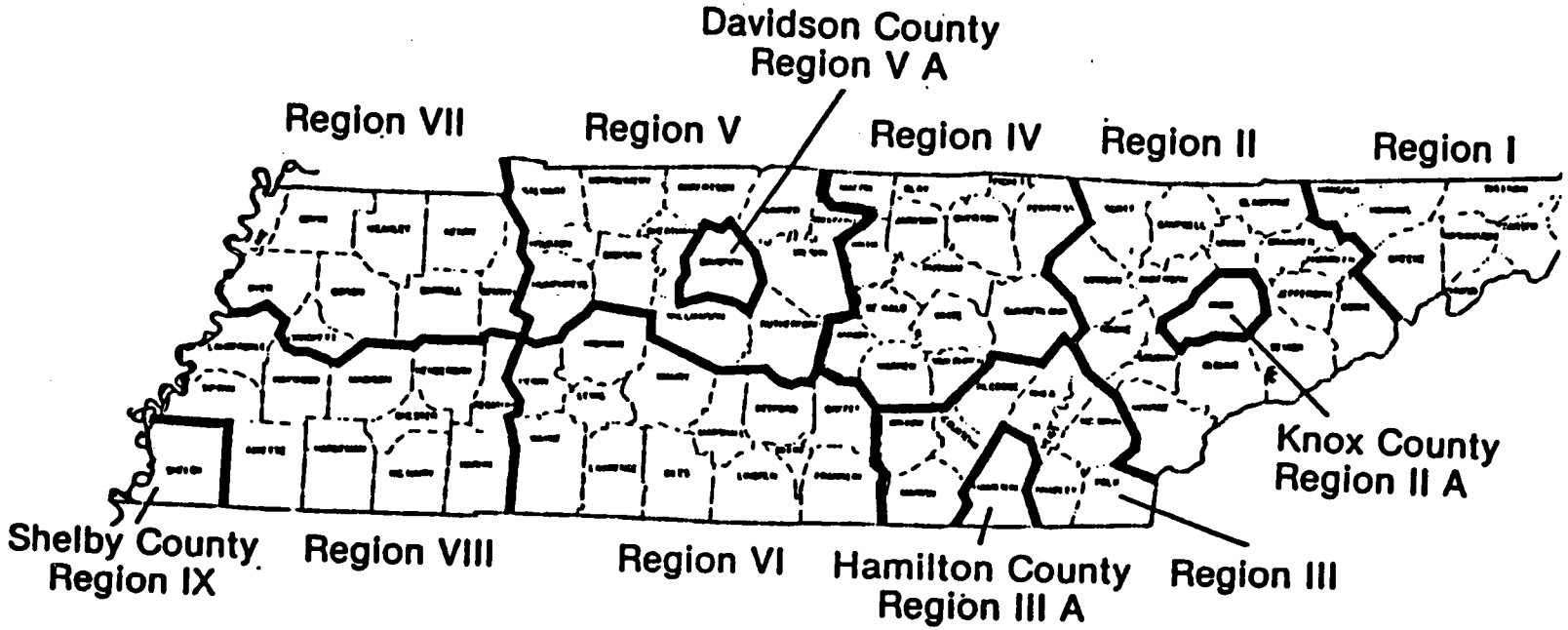
The instrument was designed to gather characteristic information about adult abuse and abusers as well as promoting the efficiency of the investigation being conducted. The instrument is a closed-form questionnaire that consisted of 26 prepared questions with a list of possible answers for each question that matched the case being investigated. The instrument was administered in the field by the social worker assigned to the client who met the criteria of abused or neglected. Some questions require a brief statement or single word comment. The instrument has 10 questions that dealt with the department's handling of the case and 16 questions involving parameters of elder abuse. Only one item focused on the abuser while 15 items related directly with obtaining information on the abused elder. The information provided by the

instrument enabled the investigator to answer the research questions asked in Chapter I.

III. Procedures in the Study

The procedure began by an inquiry the investigator made of the Tennessee Department of Human Services if a need existed for a study about parameters of elder abuse in the state. A subsequent reply (Appendix B) by the Tennessee Department of Human Services and their willingness to help in the investigator's study was followed by another letter (Appendix C) by the investigator and his advisor requesting official permission and assistance from the Department in developing parameters of elder abuse in Tennessee. Because of the confidentiality and sensitivity of the investigation, an official agreement (Appendix D) was reached where the Tennessee Department of Human Services releases information to conduct the study in exchange for the sharing of the investigation's results with the Department.

The Tennessee Department of Human Services submitted case summaries for the period ending April, 1987, on reported closed adult protective services cases for each of the 12 regions (see Figure 1 for location of each region). The case studies submitted for analysis were on computer diskette with data which had been



Eastern Regions--Region I - Region IV

Western Regions--Region V - Region IX

Urban Regions--Region IIA, Region IIIA
Region VA, Region IX

Rural Regions--Region I, Region II, Region III
Region IV, Region V, Region VI
Region VII, Region VIII

Figure 1: Map and Location of TDHS Regional Agencies and Eastern and Western Counties and Urban and Rural Counties

collected on cases closed in April, 1987. These data included everything on the questionnaire on closed adult protective services except the names which were assigned a numerical identification.

IV. Data Tabulation

The research design of this study involved descriptive research where abstract and general information was transformed to a profile of elder abuse. This was done through measures of central tendency, frequency distribution and measures of variability. The design also sought to determine if a relationship existed between two sets of variables: (1) urban counties and rural counties, and (2) eastern counties and western counties. A pilot investigation was performed using a proportions test to determine if the data in the computer diskette furnished the investigator was a true representation of the recorded data on the field. A score at the five percent level of significance was needed to satisfy the investigation.

V. Statistical Analyses

Statistical analyses were divided into three categories according to the research questions. These categories were: (1) parameters of elder abuse in the state of Tennessee; (2) the relationship between urban

and rural regions, and (3) the relationship between eastern and western regions. The last two categories are dependent on the first.

Parameters of Elder Abuse in the State of Tennessee

The following factors were included in the data collection of demographic and socioeconomic characteristics: (1) age, (2) sex, (3) urban or rural setting, (4) ethnic distribution, (5) living arrangement, (6) income level and source, and (7) relationship to abuser.

These data were of nominal measurement which was best analyzed by non-parametric statistics. Each item was tabulated and recorded in frequency tables. These tables yielded the information needed to realize characteristics of elder abuse in Tennessee. The descriptive statistical methods used measures of central tendencies, frequency distribution and measure of variability derived from the raw data provided information that characterizes the entire set of data.

The Relationship Between Urban and Rural Regions

Both the urban and rural regions provided needed data to characterize elder abuse. These data were treated as nominal levels of measurement which was best analyzed by non-parametric statistics. The mean

characteristics of each setting were compared to each other in order to determine if differences in elder abuse existed between urbal and rural counties. The analyses yielded calculated values for both of the settings included in the study.

The Relationship Between Eastern and Western Regions

Both the eastern and western regions provide needed data to characterize elder abuse. These data were treated as nominal levels of measurement which was best analyzed by non-parametric statistics. The mean characteristics of each setting were compared to each other in order to determine if a difference in elder abuse existed between eastern and western counties. The analyses yielded calculated values for both of the settings included in the study.

VI. Summary

This study sought to develop a profile of elder abuse and neglect for the state of Tennessee. The existing Tennessee Department of Human Services questionnaire on closed adult protective cases was the instrument used to gather data for investigation. The data was collected from all 12 regions covering the whole state. After the data was transferred to a computer diskette, it was tallied, summarized and analyzed.

CHAPTER IV

ANALYSIS OF DATA

This chapter presents the results of the investigation in seven sections. The first section discusses the face validity investigation on a sample of cases obtained from the Tennessee Department of Human Services. The second section presents the distribution of valid and invalid cases provided by the Tennessee Department of Human Services. The third section presents the demographic characteristics of the abused followed by the types of abuse suffered by the elderly and then the types of referrals that warranted investigation of the cases. The sixth section discusses the differences and/or similarities dealing with elder abuse found in urban and rural counties and eastern and western counties. The last section presents a profile of elder abuse in Tennessee.

I. Pilot Investigation

Since the data supplied to the researcher by the Tennessee Department of Human Services was on computer

diskette, the possibility of error in transferring the information from the questionnaire on closed adult protective cases to the diskette existed. For the pilot investigation, the researcher decided on a sample of 35 cases chosen by using a random digits table. A request was made to the Tennessee Department of Human Services to supply 35 randomly selected questionnaires on closed cases in order to validate the computer diskette printout. The Tennessee Department of Human Services complied with the request and sent the researcher the 35 cases requested including all information except the names of the clients. The simple random sample of 35 cases contains 360 possible responses from a study population of 207 with 2141 possible responses (n = 360, N = 2141). A response validation sheet on the questionnaires on closed cases assigns each matching response a score of one and each non-matching response a score of zero. (The comparison and matching findings for the pilot investigation were the computer printout results with the actual forms represented by the printout.)

The total possible responses were 2141 for the study population and if the study population represented by the computer diskette were to be considered a true representation of the actual closed-cases questionnaires, it must have five percent or less transfer error.

The proportion test using a response validation sheet denoted the proportion of ones or matched answers as 359

and the proportion or zeroes or unmatched answers as one, concluding that the proportion valid equaled 359/360 = Ø.99.

Having found that the proportion sample = Ø.99 and making allowance for chance variation in random sampling, it was inferred that the true proportion of matched responses in the computer printout and the actual questionnaires on closed cases was at least 95 percent. To validate the cases of the study population, the investigator needed to establish that the proportion of matched responses was at least 95 percent. The sample evidence from 35 cases was 99 percent valid. But can a value for the sample proportion as high as 99 percent arise merely by chance? To determine if this was just chance, a hypothesis test was performed.

Null Hypothesis : Study Population < Ø.95

Alternative Hypothesis: Study Population >= Ø.95

The calculated value for the sample population was .ØØ14 and the critical value was 3.51. The normal table indicates that the probability of obtaining a Z score as high as 3.51 was .ØØØ2 (.5ØØØ - .4998). So a Z score as high as 3.51 can arise by chance less than one percent of the time. Therefore, the null hypothesis was rejected with less than a five percent risk of rejecting a true claim. The investigator was satisfied that the information

represented in the computer diskette provided by the Tennessee Department of Human Services was at least 95 percent accurate and possibly higher.

II. Distribution of Valid and Invalid Cases

This section presents the distribution of valid and invalid cases provided by the Tennessee Department of Human Services to conduct the investigation. The frequency and percentage distribution of valid and invalid cases are presented in Table I. The cases were judged by the individual case worker on information provided by the questions on closed adult protective cases (Appendix A) as to whether or not the individual case was a valid case of abuse. All cases provided information based on the first 16 questions of the questionnaire with question number 16 asking whether the investigation of the case should continue (valid) or the investigation discontinued (invalid). Since every client investigated for possible abuse was included in the Tennessee Department of Human Services files, both those deemed valid and invalid were supplied for the research on elder abuse in the state.

The Sample

A total of 35 cases were sampled for face validation on the transfer of information from the actual questionnaire by the case worker to the electronic diskette

TABLE I

Frequency and Percentage Distribution of Valid and Invalid Cases Supplied by TDHS

Characteristic	N	Percentage*
Sample Valid	18	51
Sample Invalid	17	49
Population Valid	97	47
Population Invalid	110	53

*Percent rounded to the nearest whole number

supplied to the investigator. Eighteen cases were valid (51 percent) and 17 cases were invalid (49 percent) in the sample study.

The Study Population

A total of 207 cases were included in the electronic diskette supplied to the investigator by the Tennessee Department of Human Services. The study population had a total of 97 cases which were valid (47 percent) and 110 which were invalid (53 percent). The study conducted by the investigator focused on the 97 valid cases.

Determinants of Valid and Invalid Cases

Question 16 on the closed adult protective cases questionnaire (Appendix A) allowed for four different decisions on the types of services needed by the clients or if no services were needed at all. If protective services were needed, the cases were deemed valid. If no protective service was needed, the cases were determined to be invalid. Table II presents the frequency and percentage distribution of how all 207 cases were judged in relation to types of service needed by the clients. Out of the 97 valid cases, 78 needed and received protective services (80 percent) while 19 needed but refused protective services (20 percent). The 110 cases declared invalid indicated services were not needed for 65 persons (59 percent)

TABLE II

Frequency and Percentage Distribution of Valid and Invalid Cases Investigated

Characteristic	N	Percentage*
VALID		
Protective Services Needed and Received	78	80
Protective Services Needed but Refused	19	20
INVALID		
No Services Needed	65	59
Services Other Than Protective Services Needed	45	41

*Percentage rounded to the nearest whole number

and services other than protective services were needed by 45 persons (41 percent).

III. Demographic Characteristics of Abuse

Demographic characteristics of the abused are presented in this section. Information about the abuser was limited, therefore the information available and included in this section is only on who is the perpetrator of the abuse.

Abused

Age. The ages of the abused ranged from 60 to 95 years. Intervals of five years and ten years were used to calculate which age interval had the most abuse. Figure 2 shows the percentage value of each interval. An age of 76.4 was calculated from the cases reported as the mean age of an abused person. The age interval 75-79 represented the most abuse. This group contained 33 cases or 24 percent. The 80-89 age group represented 22 cases or 23 percent. The 70-74 age group contained 21 cases or 22 percent. The 65-69 age group represented 11 cases and 11 percent. The 90 and over group and the 60-64 age group both contained 10 cases each or 10 percent.

Sex. Out of the 97 reported cases, 34 were male for 35 percent. Sixty-three females reported abuse for 65 percent of the total (Table III).

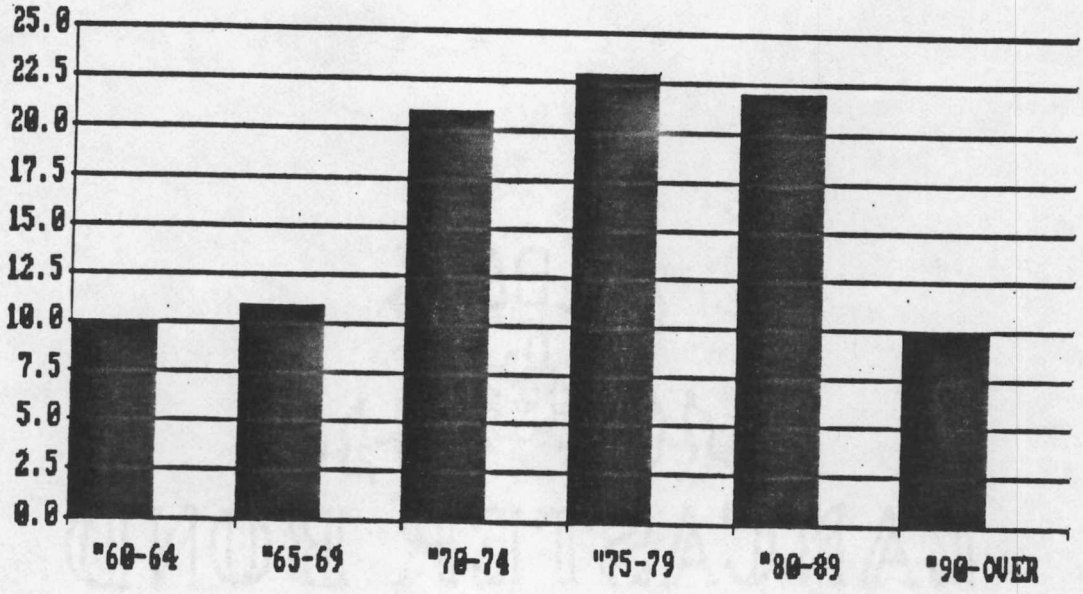


Figure 2: AGES OF THE ABUSED

TABLE III

Frequency and Percentage Distribution of
Sex and Race Characteristics of the Abused

Characteristics	N	Percentage*
SEX		
Male	34	35
Female	63	65
RACE		
Black	26	30
White	61	70

*Percent rounded to the nearest whole number

Race. Table III explains the frequency and distribution of race and report of abuse. Out of the reported cases, 26 or 30 percent were black while 61 cases or 70 percent were white.

Living Arrangements. The questionnaire provided seven different possible living arrangements as answers for the case worker to select when the case was opened. Out of the 97 cases examined, one was not answered giving the investigation 96 cases. Three possible living arrangements were not selected - nursing home; boarding, group or foster home; and mental health or mental retardation institution.

Table IV indicates the frequency and distribution of the four types of living arrangements the clients were in at the time the abuse occurred. Forty-four persons or 46 percent were living alone at the time of abuse. Forty-three persons or 45 percent were living with relatives. Of the remaining nine percent of abuse reported, five percent lived with non-relatives and four percent were in the hospital at the time the abuse was reported.

Income. The income of the clients was reported as monthly income. The monthly income ranged from a low of $0.00 per month to a high of $957.00 per month. The mean income of the abused clients was $410.70. The monthly income was arranged in intervals of $100.00 and

TABLE IV

Frequency of Percentage Distribution of Living Arrangements

Characteristic	N	Percentage*
Alone	44	46
With Relatives	43	45
With non-relatives	5	5
Hospital	4	4

*Percentage rounded to the nearest whole number

presented that way in Figure 3. Forty-eight percent of the clients had income between $301.00 and $400.00 Sixteen percent of the clients had income between $401.00 and $500.00. The $501.00 to $600.00 interval had 11 per cent, the $201 to $300.00 interval had 9 percent and then those with income over $701.00 per month constituted 6 percent of the clients reporting abuse. The remaining 9 percent of the clients had the same percentage distribution - $0.00 to $100.00 had 3 percent; $101.00 to $200.00 had 3 percent; and $601.00 to $700.00 had 3 percent.

The source of income for those reporting abuse is presented in Figure 4. Supplemental Security Income alone or in combination with other sources of income was the source of income for 35 percent of the clients. Another major portion of clients relied only on social security. This group whose only source of income was social security comprised 34 percent of those reporting abuse. Seven percent relied on a Veteran's Administration pension only or in combination with other income as their sole source while one percent was self-employed or employed by someone. Four percent reported no income at all and 18 percent indicated their income was from sources other than the 5 mentioned.

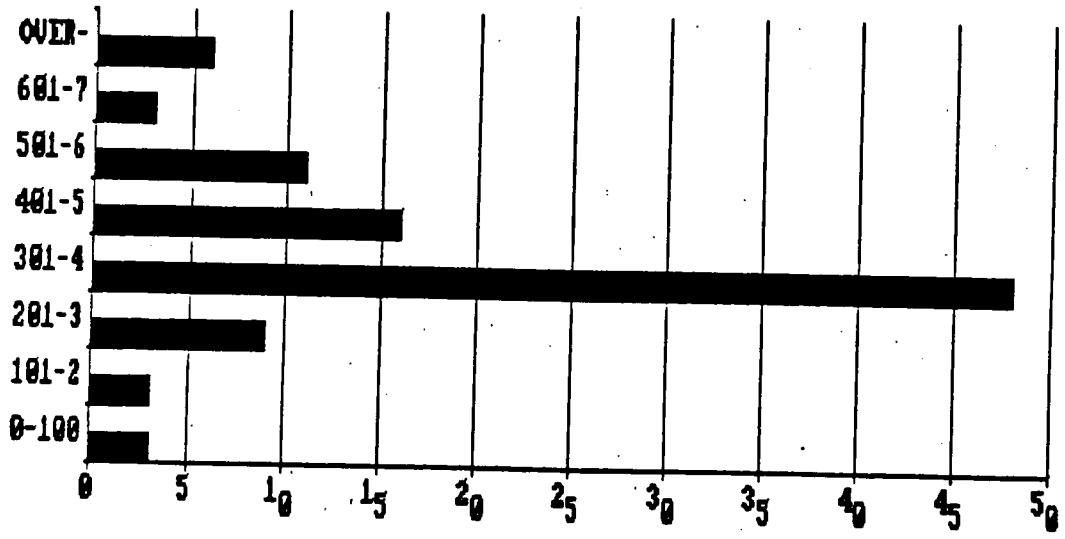


Figure 3: PERCENTAGE OF MONTHLY INCOME DISTRIBUTION

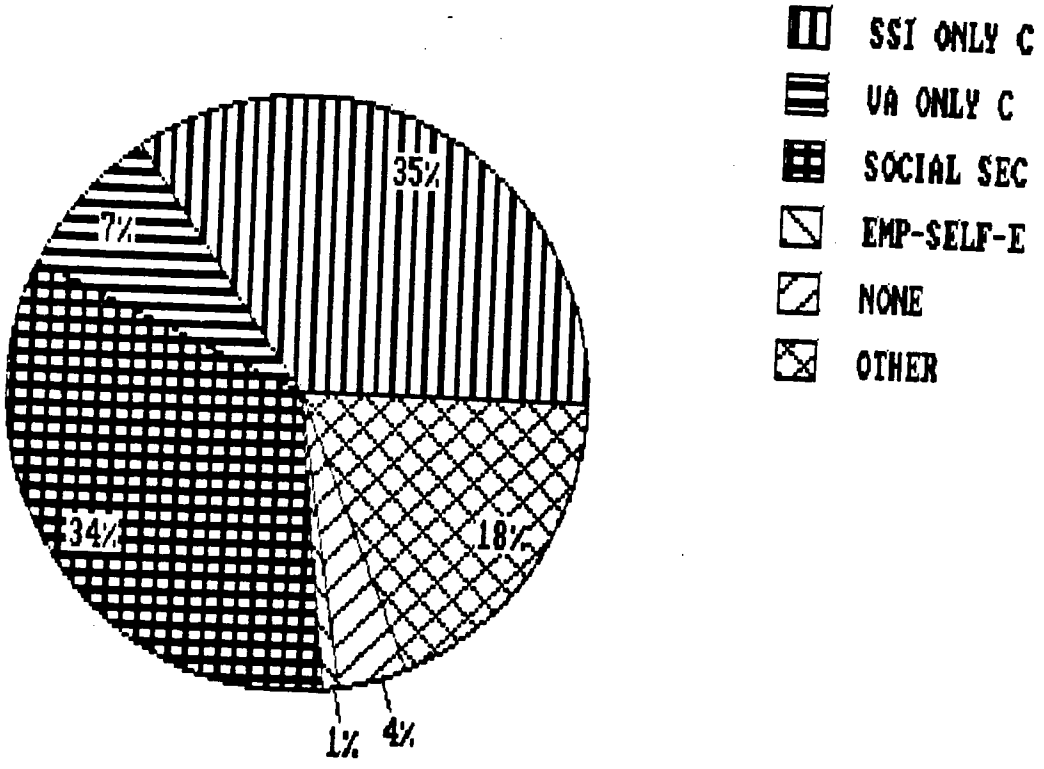


Figure 4: SOURCE OF INCOME

IV. Types of Abuse

This section is a discussion of the types of abuse that occurred and the type of protective services needed for the cases of abuse reported. Also, the perpetrator of the abused will be discussed.

Kinds of Abuse

The kinds of abuse the victims experienced and their percentages are presented in Figure 5. The questionnaire asked for six specific types of abuse and an additional response was for "other."

The single most mentioned type of abuse was self-neglect (63 percent). The second most reported type of abuse was neglect by others with 14 percent. Therefore, neglect accounted for 77 percent of the reported abuse cases. Physical abuse accounted for eight percent while physical abuse in combination with neglect accounted for five percent. Of the remaining 10 percent of the reported abuse cases, other types not in the questionnaire accounted for five percent, financial exploitation three percent and emotional abuse two percent.

Protective Services Needed

The questionnaire provided for a response to three types of protective services needed - physical dysfunction, mental dysfunction and physical and mental dysfunction in

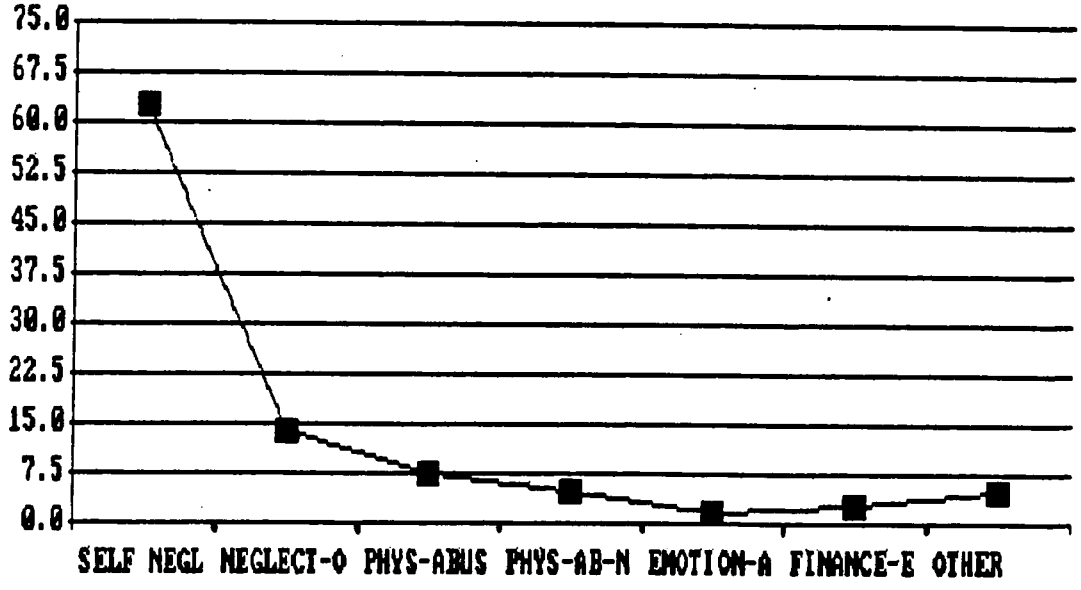


Figure 5: TYPES OF ABUSE ENCOUNTERED

combination. The frequency and percentage distribution of the type of protective services needed are presented in Table V. Protective services were needed most often for physical dysfunction (54 percent). Services for mental dysfunction clients were needed 22 percent of the time and protective services for both physical and mental dysfunction in combination were needed 24 percent of the time.

Perpetrator of the Abuse

Ten different choices as perpetrators of abuse of the elderly were included in the question dealing with the abuser. The choices and their frequency and percentages are included in Table VI. One of the choices available, self-neglect, which is really not a "perpetrator", was reported by 71 percent of the clients (68/N-97). The son of the abused was reported as abuser nine percent (8/N-97) of the time followed by the daughter with seven percent (7/N-97). Other perpetrators and the spouse accounted for three percent each while non-relatives and unknown accounted for two percent each. Grandchildren, niece/nephew, and brother/sister accounted for one percent each in total perpetration of elder abuse.

TABLE V

Frequency and Percentage Distribution of Type of Protective Services Needed

Type of Need	N	Percentage*
Physical Dysfunction	51	54
Mental Dysfunction	21	22
Physical and Mental Dysfunction	23	24

*Percentage rounded to the nearest whole number

TABLE VI

Frequency and Percentage Distribution of Relationship of Perpetuator To Abused

Relationship	N	Percentage*
Spouse	3	3
Son	8	9
Daughter	7	7
Grandchildren	1	1
Niece/Nephew	1	1
Brother/Sister	1	1
Non-Relative	2	2
Unknown	2	2
Other	3	3
Self-Neglect (no perpetrator)	68	71

*Percentage rounded to the nearest whole number

V. Referrals That Initiated Case Investigation

The types of problems which existed in the case or which greatly affected the case were presented in this section along with the types of referrals the agencies received pertaining to the elder victims. Also discussed were those who were making those referrals.

Existing Problems or Problems Affecting the Case

The questionnaire presented 11 choices for the case worker to select as to which problems existed or affected the particular case being investigated. There were a total of 117 responses in 97 cases which meant that some cases had more than one response. Table VII presents the frequency and percentage distribution of the primary problem which existed in the case or which greatly affected the case being investigated.

Poor health in the elderly was cited as the primary problem in 53 percent of the cases. Mental illness and social isolation were cited as primary problems in 15 and nine percent respectively. Other problems not listed on the questionnaire and alcoholism were each cited in six percent of the reported cases. Lack of essential transportation as a primary problem occurred three percent of the time as did mental retardation. Lack of transportation for social services was cited as a problem two percent of the time and illegal drug abuse,

TABLE VII

Frequency and Distribution of Primary Problem Which Existed in the Case or Greatly Affected Case

Problem	N	Percentage*
Illegal Drug Abuse	1	1
Social Isolation	10	9
Alcoholism	7	6
Poor Health	63	53
Mental Retardation	4	3
Unemployment	1	1
Misuse of Prescribed Medicine	1	1
Lack of Transportation (Social Services)	2	2
Lack of Transportation (Essential Need)	4	3
Other	7	6

*Percentage rounded to the nearest whole number

unemployment and misuse of prescribed mediation were each cited as a primary problem one percent of the time.

Types of Referrals

The types of referrals the Tennessee Department of Human Services received and their percentages are reported in Figure 6. The most common type of referral was non-emergency referral for poor physical health (66 percent). A non-emergency referral for poor mental health was reported 19 percent of the time. Emergency type of referral occurred 13 percent of the time with abuse or illness accounting for nine percent and those in danger of death accounting for four percent. The remaining two percent of referrals is one percent each for eviction and others not included in the questionnaire.

Those Making Referrals

Figure 7 presents 11 selections the questionnaire had for persons making referrals and their percentages of reported referrals. The referrals of those reporting elderly as possible abuse victims was more evenly distributed. The staff of social agencies other than the Tennessee Department of Human Services referred 21 percent of the elderly abused. Hospital social workers and relatives each referred 16 percent of the victims. Neighbors reported 14 percent and doctors or nurses 11

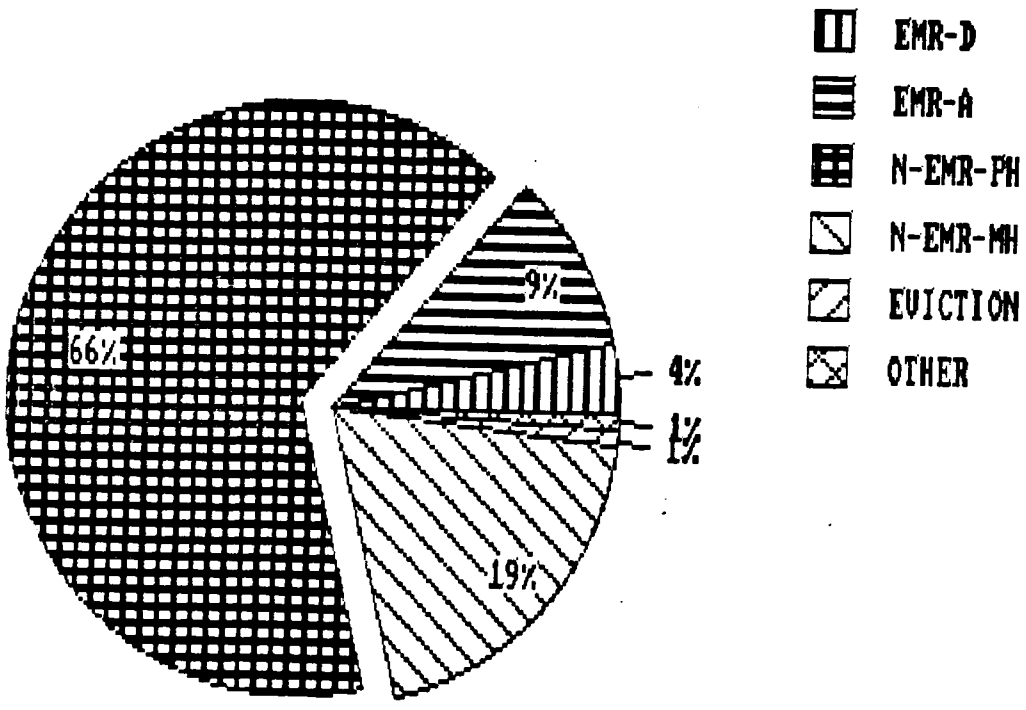


Figure 6: REFERRALS RECEIVED BY THE TENNESSEE DEPARTMENT OF HUMAN SERVICES

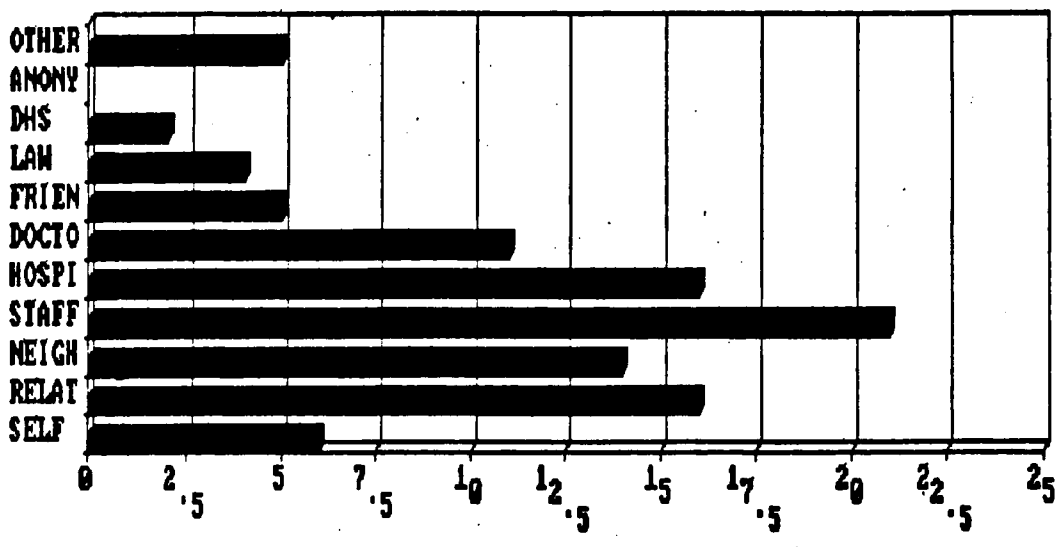


Figure 7: PERSONS WHO MAKE THE REFERRALS

percent. The abused referred themselves six percent of the time while a friend of the abused made the referral five percent of the time. Another five percent of the referrals was accounted for by different means other than those on the questionnaire. Law enforcement officials accounted for 4 percent and the Tennessee Department of Human Services accounted for 2 percent of the total referral cases.

VI. Relationship Between Eastern and Western Counties and Rural and Urban Counties

This section presents information indicating whether or not differences and/or similarities in elder abuse existed between eastern and western or rural and urban counties. The eastern, western, rural and urban counties distinguished as such for the investigation are indicated on the Tennessee map found in Appendix A. Table VIII presents the percentage of eastern and western counties reporting abuse. The east with 48 counties had 23 counties reporting abuse for 48 percent of the total and the west with 47 counties had 22 reporting abuse for 45 percent of the total. This information reveals a balanced reporting ratio. Figure 8 presents information on the valid and invalid cases reported in the eastern, western, urban and rural counties. The eastern rural counties reported a total of 34 valid cases and 22 invalid while the eastern

TABLE VIII

Frequency and Percentage Distribution of
Eastern and Western Counties Reporting Abuse

Characteristic	N	Percentage*
Total Eastern Counties	48	100
Eastern Counties Reporting	23	48
Total Western Counties	47	100
Western Counties Reporting	22	45

*Percentage rounded to the nearest whole number

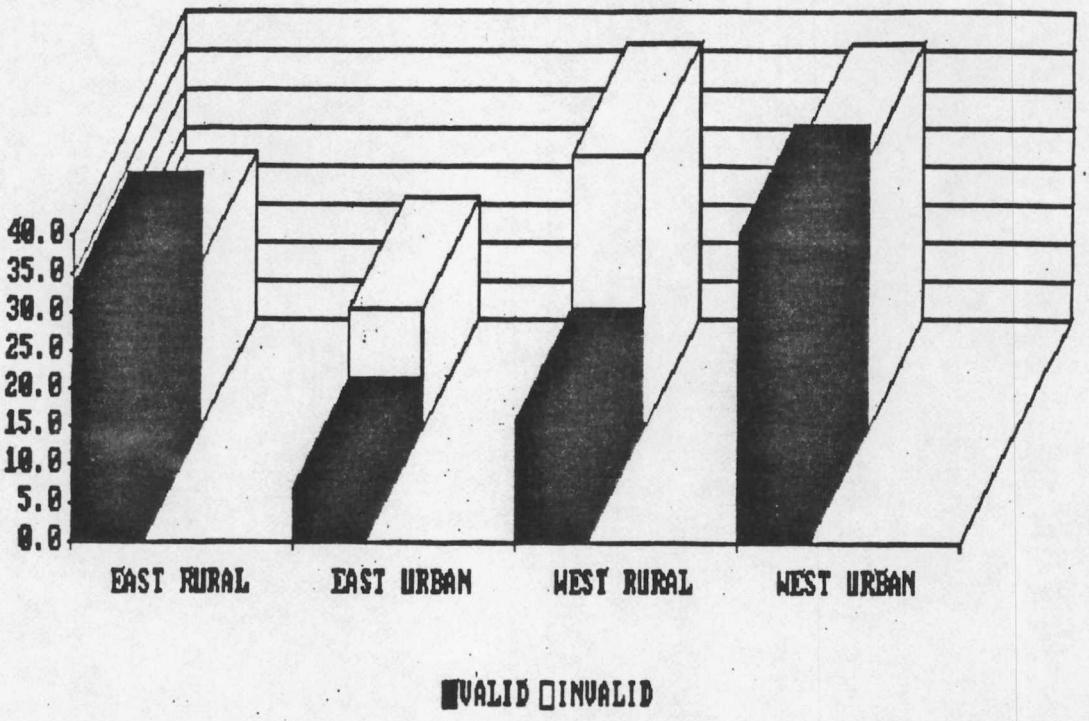


Figure 8: COMPARISON OF VALID AND INVALID CASES REPORTED IN URBAN AND RURAL COUNTIES AND EASTERN AND WESTERN COUNTIES

urban reported seven valid cases and 16 invalid. The western rural counties reported a total of 16 valid cases and 36 invalid while the western urban reported 40 valid cases and 36 invalid. A ratio reversal became evident when it was determined that the rural eastern counties have a 34 to 22 ratio of valid to invalid cases and the rural western counties have a 16 to 36 ratio valid to invalid cases reported. The ratio reversal was also true with the urban eastern counties reporting a ratio of seven to 16 valid to invalid cases and the urban western counties reported a 40 to 36 valid to invalid ratio.

Demographic Characteristics

Frequency and percentage distributions of race and sex of the abused are presented in Table IX. The male to female ratio in eastern counties was 37 to 63 percent, in western counties the ratio was 34 to 66 percent, in rural counties the ratio was 35 to 65 percent and in urban counties the ratio was 34 to 66 percent. The race distribution (with 10 percent of the data missing) was not consistent like the sex distribution. In rural counties, the percentage ratio of black to white elderly abused was 10 to 82, in urban counties the ratio was 45 to 43 percent, in eastern counties the ratio was 12 to 78 percent and in western counties, the ratio was 38 to 52 percent.

TABLE IX

Frequency and Percentage Distribution of
Sex and Race Characteristics of the Abused
in Eastern, Western, Urban and Rural Counties

	EAST		WEST		RURAL		URBAN	
Characteristic	N	%	N	%	N	%	N	%
SEX								
Male	15	37	19	34	18	35	16	34
Female	26	63	37	66	32	65	31	66
RACE								
Black	5	12	21	38	5	1Ø	21	45
White	32	78	29	52	41	82	2Ø	43

*Percentage rounded to the nearest whole number

Figure 9 presents the age distribution for the eastern, western, rural and urban counties. There was no difference or significant difference in the 60-64 age bracket, the 65-69 age bracket, the 80-89 age bracket nor the 90 years of age and over group. In the 70-74 age group the western counties reported 15 cases of abuse compared to six cases for the eastern counties and the rural counties reported 12 cases compared to nine cases for elderly abused for urban counties. Thirteen elderly abuse cases to 10 cases were reported in the 75-79 age group for both comparisons of western to eastern counties and urban to rural counties.

The mean, median and mode monthly income for the abused elderly in the western, eastern, urban and rural counties are presented in Table X. The difference in mean income in western and eastern counties was $68.64 (western $432.34; eastern $363.70). The difference in urban compared to rural counties was even more significant with the urban counties averaging $460.61 per month and the rural counties $346.53 for a difference of $114.88. The median income for western counties was $528.50 compared to the median income for counties of $309.00 for a significant difference of $219.50. The difference was just as significant when urban and rural counties median monthly income was compared. Urban counties median income was $528.50 and

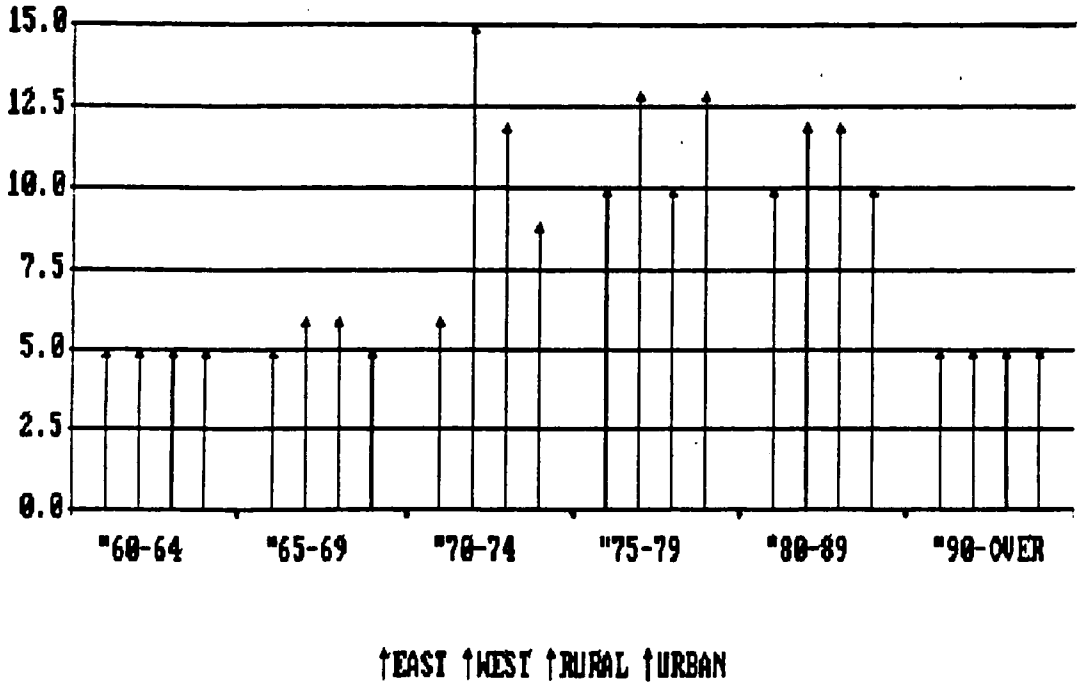


Figure 9: AGE DISTRIBUTION IN EASTERN, WESTERN, URBAN AND RURAL COUNTIES

TABLE X

Monthly Income of Adult Clients

Average Income = $410.70

Income	East	West	Rural	Urban
Mean	363.70	432.34	346.53	460.61
Median	309.00	528.50	311.00	528.50
Mode	340	360	360	360

rural counties median income was $311.00 for a difference of $217.50. The mode monthly income for the eastern, western, rural and urban counties was $360.00, $340.00, $360.00 and $360.00.

Types of Referrals

There was not much difference in referrals pertaining to eviction, other, emergency danger of death and emergency abuse/illness as presented in Table XI. Non-emergency poor mental health type of referrals did show significant differences. Western counties reported 12 cases and eastern counties reported 6 cases; urban counties reported 12 cases and rural counties reported 6 cases. The other type of referral that indicated differences in eastern and western counties and urban and rural counties was for non-emergency poor physical health. Western counties reported 38 cases while eastern counties reported 26 cases and rural counties reported 35 cases while urban counties reported 29 cases.

Types of Abuse and the Abuser

The types of abuse as shown in Table XII indicates that there are not significant differences in the reporting of self-neglect, emotional abuse and financial exploitation in the eastern, western, rural and urban counties. Self-neglect was the most prevalent type of abuse reported

TABLE XI

Frequency of Types of Referral Received by the TDHS

Type	East	West	Rural	Urban
Emergency danger of death	3	1	3	1
Emergency abuse/ill	5	4	5	4
Non-emergency poor physical health	26	38	35	29
Non-emergency poor mental health	6	12	6	12
Eviction	1	--	--	1
Other	--	1	1	--

TABLE XII

Frequency of Types of Abuse
Clients Experience

Type	East	West	Rural	Urban
Self neglect	30	32	28	34
Other neglect	1	12	6	7
Physical abuse	3	4	5	2
Physical abuse and neglect	4	1	3	2
Emotional abuse	1	1	1	1
Financial exploitation	2	1	2	1
Other	-	5	5	-

and was constant in all four areas investigated. Neglect by others did not show much difference between rural and urban counties (a six to seven ratio), but eastern and western counties did show a big difference with one reported case in the eastern counties and 12 reported cases of abuse in the western counties. Eastern counties reported three cases of physical abuse and western counties reported four cases of physical abuse but the rural counties with five reported cases were significantly higher than the urban counties in physical abuse reports. Physical abuse in combination with neglect was reported three times in rural counties and twice in urban counties. The eastern counties had four reports of physical abuse in combination with neglect as compared to only one report for the western counties. Other types of abuse not included in the questionnaire were not reported at all in eastern and urban counties while western and rural counties each had five reported cases.

The frequency and percentage distribution of the perpetrator of the abused for eastern, western, urban and rural counties is presented in Table XIII. Self-neglect was the most frequent choice reported with some differences of frequency between eastern and western counties and urban and rural counties. Western counties cited self-neglect 66 percent of the time and eastern counties 78 percent. Rural counties cited self-neglect 67

TABLE XIII

Relationship of Perpetrator to Abused

	EAST		WEST		RURAL		URBAN	
Characteristic	N	%	N	%	N	%	N	%
Spouse	1	3	2	4	2	4	1	3
Son	3	8	5	9	4	9	4	9
Daughter	1	3	6	11	3	6	4	9
Grandchildren			1	2			1	2
Niece/Nephew	1	3			1	3		
Brother/Sister			1	2			1	2
Non-relative			2	4	1	2	1	2
Unknown	2	5			2	5		
Other	1	3	2	4	3	6		
Self-neglect (no perpetrator)	31	78	37	66	33	67	35	74

percent of the time and urban counties 74 percent. The largest difference between the counties investigated was when the daughter was listed as perpetrator. Eastern counties named the daughter as perpetrator in three percent of the reported cases while western counties name the daughter 11 percent of the time. Rural counties named the daughter as perpetrator six percent of the time while urban counties cited the daughter as perpetrator in nine percent of the reported cases. The son as perpetrator in reported cases did not see much variation between eastern (eight percent) and western (nine percent) counties and rural (nine percent) and urban (nine percent) counties. The spouse of the abused victim also did not vary much in being cited as perpetrator of abuse: eastern counties, three percent; western counties, four percent; rural counties, four percent; and urban counties, three percent. Grandchild as perpetrator was reported two percent of the time in both western and urban counties, niece/nephew as perpetrators were reported three percent of the time in eastern and rural counties, brother/sister as perpetrators were cited two percent of the time in western and urban counties and unknown perpetrators were cited five percent of the time in eastern and rural counties. Non-relatives were reported as perpetrators four percent in western counties and two percent each in rural and urban counties. Other perpetrators not listed in the questionnaire were

reported as perpetrators three percent in eastern counties, four percent in western counties and six percent in rural counties.

VII. Profile of Elder Abuse in Tennessee

The abused elder in Tennessee derived from cases closed during the month of April, 1987, was 76 years old, white and female. The abused victim tended to live alone or with relatives, had a mean income of $410.70 and derives her income from either social security or supplemental security income. The most common type of abuse encountered was self-neglect. Physical dysfunction was the resultant of that neglect which produced poor health in the typical elder victim. The most common referral to the Tennessee Department of Human Services was a non-emergency referral for poor physical health. The people making those referrals were relatives, neighbors, social workers, social agencies and health care delivery personnel. Although the typical elder abused person was described in the said information, other variables should be noted to present a more exact profile of elder abuse in Tennessee.

Without a doubt, the typical eastern rural abused person was a white female but the typical western urban abused person stood as good a chance to be a black female as a white female. Although the mean age was presented as 76, it must be noted that 22 percent of abuse reported was

in the 70-74 age group, 24 percent was in the 75-79 age group and 23 percent was in the 80-89 age group which presented a picture that most abuse occurred to a person older than 76 (Table XIV). Table X, page 86, presented information on income that indicated further explanation of the average income of the typical abused person needed clarification. The median income for urban and western counties is $528.00 while the median income for rural and eastern counties is $310.00.

According to the study findings presented in Table XV, there is a distinction in the type of protective services needed by the typical abused person when looked at from the variables of eastern, western, urban and rural counties. Statewide, the elder abused needed protective services for physical dysfunction, but physical dysfunction in combination with mental dysfunction had just about as much chance as appearing in eastern and rural counties as did physical dysfunction by itself.

Based on the study findings, the profile of elder abuse presented was correct, but caution should be taken because of geographical differences that influenced demographical variations and because differences existed statewide, the typical profile of elder abuse may have variations when considered in western, eastern, urban or rural counties.

TABLE XIV

Ages of the Abused

Age	East	West	Rural	Urban
Mean	76.14	76.53	75.72	77.06
Median	76.50	78.00	77.00	78.00
Mode	80	74 & 79	80	74&79

TABLE XV

Frequency and Percentage Distribution of Reason for Protective Services Needed

	EAST		WEST		RURAL		URBAN	
Type of Need	N	%	N	%	N	%	N	%
Physical dysfunction	19	47	32	58	24	50	27	50
Mental dysfunction	5	13	16	29	6	13	15	32
Physical and mental dysfunction	16	40	7	13	18	37	5	11

VIII. Summary

This chapter presented an analysis of the data that were furnished by the Tennessee Department of Human Service on 207 elderly victims that reported or were reported as abused. Presented here was a face validation of a sample to establish correct transfer of data from the written questionnaire to computer diskette, and results of the valid and invalid cases provided. Also, demographic characteristics of the abused, the types of abuse the victims incur, referrals that initiate case investigation, the relationships between eastern and western counties and urban and rural counties and a profile of elder abuse in Tennessee were discussed.

CHAPTER V

SUMMARY, FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

I. Summary

The purpose of this study was to survey elder abuse cases reported to the Tennessee Department of Human Services and develop a profile of elder abuse for Tennessee. This investigation looked at information compiled by the Tennessee Department of Human Services in order to answer five research questions: (1) What are the demographic characteristics of the abused? (2) Who is the perpetrator of the abuse? (3) What types of abuse occur? (4) What is the relationship in elder abuse between rural and urban counties? and (5) What is the relationship in elder abuse between eastern and western counties?

The cases of elder abuse surveyed were closed during the month of April, 1987, and were furnished to the investigator on computer diskette. The instrument used for data collection was the Tennessee Department of Human Services own questionnaire on closed adult protective

service cases. The questionnaire consisted of 28 questions of which 13 pertained and were used for the study.

The review of related literature consisted of definitions of elder abuse, incidences and prevalence of elder abuse, factors connected with elder abuse, intervention in elder abuse and types of assessments in elder abuse. References to early research in the area of elder abuse are cited as well as congressional committee positions taken as a result of studies that brought the hidden problem of elder abuse to local, state and national attention. Victim and abuser profiles are presented as well as the inconsistency of state laws requiring the reporting of elder abuse and the problems this causes in assessment.

The subjects for this study were individuals 60 years and older who lived in the state of Tennessee. The subjects reported cases of abuse or were reported as abused to the agencies of the 12 regions within the Department of Human Services. The cases studied were those closed during April, 1987.

The data surveyed were nominal in scale, therefore it was analyzed using measures of central tendency. Frequency and percentage distributions were computed for the data and were presented in table form, bar graphs, and pie charts. The data related to the pilot investigation as well as valid and invalid cases found in

the computer diskette, information about the abuser, the abused and the types of abuse incurred. Additional analysis consisted of describing similarities and/or differences in elder abuse found in urban and rural counties and in eastern and western counties.

II. Findings

Based upon the investigation, the following findings are presented:

1. No significant transfer error from actual questionnaire to computer diskette was found in the sample of cases studied. At the five percent level of significance, the total number of cases looked at were a true representation of what agency caseworkers wrote on the questionnaire.

2. Sixty-five percent of those reporting abuse were female and 70 percent of cases reporting race were white.

3. White females 76 years of age or older had the highest likelihood of suffering from abuse or neglect on a statewide basis.

4. When sex and race information was considered on a regional basis, a black female 76 years of age or older stood the same chance as a white female 76 years of age or older to suffer abuse in western and urban counties.

5. Spouse or relatives as perpetrators account for 22 percent of abuse reported.

6. Sixty-three percent of elder abuse reported was self-neglect and 14 percent of elder abuse was neglect by others. The 77 percent of neglect is presented under abuse because of the questionnaire format.

7. Physical abuse by itself or in combination accounted for 13 percent of the cases reported.

8. The primary problem resulting from abuse and neglect was poor health for the elderly.

9. The elder victims of abuse and neglect lived alone 46 percent of the time and with relatives 45 percent of the time.

10. Of those elderly reported for self-neglect, 34 percent did not live alone and self-neglect occured while living with someone or under the care of others (54% of 63% = 34%).

11. Abuse and self-neglect was a problem more readily seen by others than by those suffering from it since the self-reporting incidence rate is only six percent.

12. The mean income for the abused and neglected elderly was $411.00 a month, mostly from social security, supplemental security income and veterans benefits.

13. Demographical and geographical differences existed and should be considered and taken into account when profiling elder abuse and neglect.

III. Conclusions

The analysis of the findings indicates the following conclusions:

1. The typical abused elder in Tennessee is a white female 76 years old who lives alone or with relatives and obtains most of her income from social security.

2. The elder victim is also most often the perpetrator of the abuse. This is manifested in the form of self-neglect. Less often the perpetrator is a spouse or relative. This is usually manifested in the form of physical or psychological abuse.

3. Neglect and self-neglect are much more common than other types of abuse.

4. Elders residing in rural or urban counties are very similar in regard to perpetrator of abuse, the type of abuse incurred, the typical age of the victim, and the sex of the victim. They are dissimilar in regard to race and income with the urban counties having a substantially greater number of black victims and a higher monthly income.

5. Eastern and western counties are similar in regard to perpetrator of abuse, the type of abuse incurred, the typical age of the victim and the sex of the victim. In contrast to the above, the eastern and western counties differ in regard to race and income with western counties

having a substantially greater number of black victims and a higher monthly income.

IV. Recommendations

The recommendations that resulted from this study center around the most predominate type of problem the elderly face -- neglect either produced by others or self-imposed.

1. It is recommended that a workable and acceptable definition of neglect be established. This definition should be developed by geriatricians, elderly persons, health care professionals, social workers, and educators.

2. All agencies that interact with the elderly should work together under a said definition of neglect to assess and intervene in behalf of those affected.

3. The questionnaire on closed adult protective cases should ask if the client presently investigated has had a previous case with the Tennessee Department of Human Services. Also, cases reported and deemed invalid by caseworkers should be identified with follow-ups and careful attention paid to them by social service personnel.

4. It is important to find out how the distributions and determinants of aspects of health in the elderly are related or are a result of social epidemiology. Social variables play a big part in the well-being of individuals and certainly the elderly cannot be excluded.

5. It is imperative that a strong educational effort be undertaken to provide workshops and seminars for the elderly, their caretakers, and those who interact with the elderly. These seminars and workshops should seek to promote and organize support groups concerned about the welfare of the elderly.

6. Recommendations for further study include comparing the social networks of the invalid cases to those deemed valid. Cause and effect relationship should be determined in any subsequent studies.

7. Studies should also be conducted to determine guidelines for the uniform assessment of abuse and neglect.

CHAPTER VI

EPILOGUE

I. Tennessee Department of Human Services

It is considered by the investigator that the Tennessee Department of Human Services is doing a good job in investigating, reporting, recording and intervening on behalf of victims of elder abuse and neglect. The Department's willingness to provide the investigator the necessary information to conduct this study with a stipulation that the findings be shared with them is a positive indicator that the Department is willing to look at itself for possible strengthening and evaluation. The people with whom the investigator has been in contact have been most cooperative, congenial and helpful. The investigator has sensed a loyalty and dedication to each other, to their job and to those they serve.

At a time when more efforts and appropriations should be allocated to further unmask the problems of elder abuse and neglect, the state of Tennessee has cut down the number of regional offices it maintains. This investigator

received information from 12 regional offices, but under new administrative reorganization, the reporting regions have been cut to nine. This is an unfortunate signal the dedicated employees received not to mention the message going to those who give the department reason to exist--victims of elder abuse and neglect. Any cutbacks in the Adult Protective Services of the Tennessee Department of Human Services suffers may make it all but impossible to implement an educational program recommended in this study. The educational program, consisting of literature, conventions, seminars and workshops is intended to educate and inform all agencies and parties that come in contact with the elder population about ways and means of screening and assessing elder abuse and neglect. This study found that the Department of Human Services accounts for only two percent of reported elder abuse and neglect cases. Therefore, it is imperative that personnel from other agencies or groups learn how to screen and assess for abuse and neglect. To many, abuse implies fractures, lacerations, burns, welts or bruises. So a mind-set bent on looking for such things will miss neglect, particularly self-neglect.

Neglect should never be seen as a lesser form of elder abuse but as real abuse that is creating physical and mental problems for a portion of our elderly population. Physical abnormalities have been used as

indicators in screening for warnings of elder abuse and neglect. But those abnormalities should be expanded to include conditions such as confusion, disorientation, memory loss or impairment, lethargy, malnutrition and poor physical hygiene. Since neglect and self-neglect account for 77 percent of all cases of elder abuse in the state, there is the justification for a vast educational blitz conducted by the Adult Protection Services for all groups, parties and agencies and individuals likely to come in contact or report elder neglect.

The literature tells us there is much more elder abuse and neglect than is reported. Therefore, teaching awareness of the problem along with screening and assessment techniques to as many people as possible who are potential reporters of elder abuse and neglect is a maneuver the Adult Protective Services should employ in helping it help the elder victims.

II. Instrument

The fact the Department of Human Services has in the past modified and revised the questionnaire on Adult Protective Services Cases is a healthy indicator the Department is seeking ways to improve and better collect information.

Two areas that would strengthen the instrument are found in Chapter 25 of the Tennessee Adult Protection Act

of 1978. First, the area requiring information of abuse and neglect is a recurring problem with the adults; and second, making abuse and neglect reporting mandatory for those persons encountering the problem. A third area that would strengthen the questionnaire is to make neglect a separate category to be investigated and not included with information about the perpetrator and types of abuse encountered. Neglect as a separate category would allow the caseworker to identify a certain problem or problems that influence him/her in making that particular choice.

Intervening in a problem of abuse and neglect would be better handled if information revealed if a particular person had had a previous referral for abuse or neglect. Information about previous referrals should be looked at as very important whether or not the referral was deemed valid or invalid by the caseworker. This type of information could reveal flaws in assessment of valid and invalid cases. It is better to validate a case that might indeed be invalid than to invalidate a true valid situation that needs attention. The law requiring reporting of abuse and/or neglect could best be complied with if those having the most contact with the elderly knew what to look for. The review of related literature discusses The Elder Assessment Protocol (TEAP) developed by Dr. Terry Fulmer and her associates of the Beth Israel Hospital Elder Assessment Team in Boston, Massachusettes. This instrument

was developed because of the need for a readily available tool to assess and target potential victims of elder abuse and neglect. Important variables the literature has shown that might indicate abuse and/or neglect are included in the TEAP. Variables included are general assessment, physical assessment, usual lifestyle, social assessment, medical assessment, summary assessment and disposition. The TEAP was revised in May, 1986, and retitled the Elder Assessment Instrument. This tool is mentioned because the investigator believes that information found therein can be incorporated into the present questionnaire on Closed Adult Protective Cases allowing for better screening and assessment. Terry Fulmer's address and telephone number at the Harvard Medical School are found in Appendix E if correspondence with her is desired.

III. Findings

Not all the material reviewed in Chapter II provided the same reasons nor arrived at the same conclusions about elder abuse and neglect. The literature both agreed and disagreed with the findings in this investigation as to the most prevalent type of health related problem encountered by the elderly. Why all elder abuse investigations have not come up with the same conclusions in defining a prevalent type is not known, but the manner in which information is sought and the mind-set of the

investigator could possibly explain the reasons for inconsistencies. The literature is also clear that value judgments by those deciding whether or not to assess a situation as abusive or neglectful plays a part in how a case is determined. The evaluator's perception of the caregiver of the elderly or the elder person's relationship with the caregiver can and often does influence how cases are identified. For this and other reasons, different definitions for the categories of abuse and neglect must be agreed upon.

IV. Neglect or Abuse

We must differentiate neglect from abuse and stop considering neglect as a subcategory of abuse. Neglect and self-neglect are the main contributors to the health problems affecting the elderly in cases investigated by the Adult Protection Agency. Abuse, which is different from neglect, accounted for only 13 percent of the problems the elderly reported. Because of this fact, it would be advisable if efforts be implemented to develop an index of high risk indicators for suspected neglect or self-neglect cases. Caution should be taken that indicators are just what the word implies and not taken to mean that an item or incident qualifies automatically as neglect.

Issues of responsibility need consideration since neglect assumes someone or somebody is not fulfilling

their duties, whereas abuse implies direct deliberate action. Neglect is not abuse in the same fashion that grape nut flakes are not grapes nor nuts. Since neglect is responsible for poor health in the elderly, there should be means of quick reaction to their needs. Because the elderly's physiological reserves decrease with age, they cannot afford to wait and have their cares go unnoticed, unresolved, or unreported. Also, neglect instead of abuse needs to be addressed as to why it occurs and why it is occuring so frequently.

Those who provide social support services have some idea of what abuse is and possibly even know how to identify it, but can we say the same thing about neglect? Personnel providing such services should be surveyed on awareness of neglect, extent of neglect and their commitment to educate and be educated in matters of neglect.

The types of referrals in elder abuse cases that dealt with physical or mental problems totaled 98 percent. If these cases were evaluated and diagnosed by the medical model, then only problems involving biomedical function would be addressed. This is true if we are looking at resultants of neglect and especially abuse as a physical phenomenum. It is strongly recommended that diseases and problems affecting the elderly be looked at as social conditions. Social variables account for a big portion of well-being in individuals and social factors may need more

attention than physical factors in trying to learn more about abuse.

A caveat in assessing neglect or self-neglect comes from the literature which tells us that the elderly are known to average three-and-one-half health related problems per person. It is understandable that there is a high level of suspicion of neglect when the elder is in a deteriorated state, but careful assessment should consider whether or not the problems experienced by the victim are not the result of the aging process. For this reason, a clinical assessment program staffed by concerned medical personnel may be necessary. This clinical assessment program or team should also be on guard not to let the fact that an elder person experiences three-and-one-half chronic diseases be a reason to dismiss neglect or write it off as a by-product of aging. It is imperative that assessors of elder neglect be as discriminating and compassionate as possible in their evaluation.

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APPENDIXES

APPENDIX A

QUESTIONNAIRE ON CLOSED ADULT PROTECTIVE SERVICES

QUESTIONNAIRE ON CLOSED AUDLT PROTECTIVE SERVICE CASES

1. Month Closed _____ 2. County Name _____ Case ID# _____

4. County No. ____ Unit ____ Workers ID# ____ 5. Individual Client _____

6. Age of client when case was opened: (Write in) ____ 7. Sex (Circle One) M F

8. Race (Circle One) a. White b. Black c. Other

9. Referral was primarily based on: (Circle one most significant)

a. Self-neglect c. Physical abuse e. Emotional abuse g. Other: Explain _____
b. Neglect by other(s) d. Physical abuse & neglect by other(s) f. Financial exploitation _____

10. Referral made by: (Circle One)

a. Self d. Staff of other social agency g. Friend j. Anonymous
b. Relative(s) e. Hospital Social Worker h. Law enforcement k. Other: Explain _____
c. Neighbor f. Doctor/Nurse i. DHS staff

11. Referral was an: (Circle One)

a. Emergency: alleged imminent danger of death e. Eviction
b. Emergency: abused or seriously ill, no allegation of imminent danger of death f. Abandoned or wandering with no residence
c. Non-Emergency: poor physical health, unable to meet basic needs
d. Non-Emergency: poor mental functioning, unable to meet basic needs g. Other: Explain _____

12. After receiving the referral the investigation was initiated within (working days): (Circle One)
(a) 0 to 3 hours (b) 1 day (c) 3 days (d) 1 week (e) 2 weeks (f) 3 weeks (g) More than 3 weeks

13. When case was opened the adult was living: (Circle one, most appropriate answer)
a. Alone c. With non-relatives e. Boarding, group or foster home g. Mental health or mental retardation institution
b. With relatives d. Nursing home f. Hospital

14. Write in total number of hours required after regularly scheduled working hous (after scheduled work day or on weekends) during time case was open. _____

15. Write in total number of case contacts made in the first 60 days:
a. Phone calls _____ b. Home/collateral visits _____ c. Office visits _____

16. Investigation revealed: (Circle One)
a. Valid case protective services needed and received c. Invalid case, no services needed
b. Valid case protective services needed but refused d. Invalid case, but services needed other than protective services

- - - - - - - - - - - - - - - - - - If Case Invalid, Do Not Complete Form Beyond This Line - - - - - - - - - - - - - - - - -

17. In cases needing protective services the adult was unable to protect himself/herself based on: (Circle one most significant)
a. Physical dysfunctioning b. Mental dysfunctioning c. Physical and Mental dysfunctioning

18. Perpetrator was: (Circle One)
a. Self-neglect, no perpetrator
b. Spouse
c. Son
d. Daughter
e. Parent
f. Grandchild(ren)
g. Bro./Sister-in-law
h. Neice/Nephew
i. Brother/Sister
j. Non-relative
k. Facility/Institution Staff
l. Unknown
m. Other: Explain _____

19. In cases needing protective services the need was for: (Circle one or more most significant.)
a. Counseling/casework with adult or family
b. In-home services (homemaker, meals, etc.
c. Boarding, group or foster home
d. Mental Health evaluation, treatment or placement
e. Alternate/better housing
f. Hospitalization
g. Nursing home care
h. Transportation
i. Day Care
j. Other: Explain _____

20. Income of each adult client: (Write in amount or circle correct response)
(a) Write in amount _____
(b) No income, supported by spouse or others
(c) No income, no support
In institutional setting, income payments paid directly to facility for care:
(d) Medicaid
(e) Other sources of payment

21. Source of income: (Circle One)
a. SSI only or in combination
b. VA only or in combination
c. Social Security, only
d. Employed or Self-Employed
e. None
f. Other: Explain _____

22. Legal action initiated by DHS: (Circle One)
a. No b. Yes, court order was granted c. Yes, but court order was not granted

23. If yes, and a court order was granted then indicate type of order: (Circle one or more)
a. Consent to medical placement
b. Consent to non-medical placement
c. Consent to medical care
d. Consent to surgery
e. Provide services
f. Search warrant
g. Injunction
h. Commitment
i. Guardian/conservator appointed
j. Probable cause, examination only

24. Legal action initiated by other person or agency (not DHS): (Circle One)
a. N/A
b. Guardianship/Conservatorship
c. Commitment
d. APS Petition by Private Non-Profit Agency
e. Other: Explain _____

25. The primary problem which existed in the case was caused by or greatly affected by: (Circle One or more)
a. Illegal drug abuse
b. Social isolation
c. Alcoholism
d. Poor Health
e. Mental Retardation
f. Mental Illness
g. Unemployment
h. Misuse of prescribed medication
i. Lack of transportation for needed social service
j. Lack of transportation for essential needs (food, utilities, medication, etc.)
k. Lack of money for food, shelter or utilities
l. Other: Explain _____

26. Services greatly needed by this client which were not available: (Circle one or more, most significant)
a. None - all needed services were available
b. Homemaker
c. Nursing Home
d. Chore
e. Home delivered meals
f. Guardian/Conservator
g. Day Care
h. Public/Subsidized Housing
i. Boarding, Group or Foster home
j. Other: Explain _____

27. Reason for closure: (Circle One)
a. Goals met/Services no longer needed
b. Client institutionalized (nursing home, hospital, etc.)
c. Refused services
d. Client deceased
e. Client moved/address unknown
f. Other: Explain _____

28. Case was open for: Write in total number of months. _____ (Less than 1 month, use 1 month. All others round to nearest whole month.)

APPENDIX B

LETTER FROM TENNESSEE DEPARTMENT OF HUMAN SERVICES

STATE OF TENNESSEE
DEPARTMENT OF HUMAN SERVICES
400 DEADERICK STREET
CITIZENS PLAZA BUILDING
NASHVILLE, TN 37219

February 17, 1987

Mr. Paul Villes
Tennessee Temple University
1815 Union Avenue
Chattanooga, TN 37404

Dear Mr. Villes:

In follow up to our telephone discussion regarding your interest in developing a profile on elder abuse for your dissertation, I discussed your request with Marilyn Whalen, Program Director for Adult Protective Services. Mrs. Whalen requested a written request specifying the information you would like to have from the department.

In Tennessee, protection from abuse, neglect, or exploitation may be provided to a physically or mentally dysfunctional adult of any age, or an elderly adult who is unable to protect himself/herself. The information collected from the questionnaires completed on adult protective service cases closed in January, April, July and October, pertains to adults of all ages.

For your information, a copy of the questionnaire on closed adult protective service cases and Chapter 25, The Adult Protection Act, including the 1986 revisions to the Act, are enclosed for your review.

You may reach me or Mrs. Whalen at (615) 741-5926 if you have any questions.

Sincerely,

Ruby H. Burford

Ruby H. Burford
Program Specialist
Adult Protective Services

RHB:rt

Enclosures

APPENDIX C

LETTER TO TENNESSEE DEPARTMENT OF HUMAN SERVICES

THE UNIVERSITY OF TENNESSEE
KNOXVILLE

College of Education
Department of Health, Leisure, and Safety

March 3, 1987

Mrs. Marilyn Whalen
State of Tennessee
Department of Human Services
400 Deaderick Street
Citizens Plaza Building
Nashville, TN 37219

Dear Mrs. Whalen:

As per the instructions of Mrs. Ruby Burford, this is to request permission and assistance from you to develope a profile of elder abuse for the State of Tennessee.

I am working on a doctoral degree at the University of Tennessee and for my dissertation, I would like to profile elder abuse in the State. I am enclosing what would be Chapter One of my dissertation wherein I explain the needs and reasons for the research. The chapter will give you a good idea of what I propose to do.

Dr. Bill Wallace, who is professor of Gerontology at the University of Tennessee and on the Tennessee Commission of Aging and on the advisory board of area 2A of the Department of Human Services, is serving as my advisor. Both of us recognize the confidentiality and sensitivity of the information needed to be able to come up with parameters of elder abuse and neglect for Tennessee. We would certainly be willing to abide by any guidelines you would set forth.

The information that I need for my research is found in the reported cases to your department that come from questionnaires on closed adult protective services cases. At the present, I would like to profile the whole state, so it would be imperative that each county cooperate.

Thank you very much for your consideration. I feel certain you will want more information from me. You can call me at (615)493-4275 or write me at Tennessee Temple University, 1815 Union Avenue, Chattanooga, TN 37404.

Very sincerely,

Paul Villas

Dr. Bill Wallace, Advisor

dm

1914 Andy Holt Avenue/Knoxville, Tennessee 37996-2700/(615) 974-5041

APPENDIX D

LETTER FROM TENNESSEE DEPARTMENT OF HUMAN SERVICES (AGREEMENT)

STATE OF TENNESSEE
DEPARTMENT OF HUMAN SERVICES
400 DEADERICK STREET
CITIZENS PLAZA BUILDING
NASHVILLE, TN 37219

April 6, 1987

Mr. Paul Villas
TN Temple University
1815 Union Ave
Chattanooga, TN 37404

Dear Mr. Villas:

This letter is a confirmation of the agreement between you and this department.

Due to the limited availability of research and data on Adult Protective Service clients and the need for this department to have a thorough understanding of adults who are receiving protective services, we have agreed to share with you information obtained from questionnaires completed on closed Adult Protective Service cases. It is intended that results of your analysis\research be shared with the Tennessee Department of Human Services for use in more fully understanding client needs and in enhancing the ability of the department to administer the Adult Protective Services program.

The agreement which has been reached with you is that:

1. The Tennessee Department of Human Services will give to you a computer disc with the data which has been collected on cases closed in July, 1985. This data will exclude case names but will include a number assigned to each case. There will be cases with more than one adult client under the same case number.

2. The results of your analysis\research will be shared with the Tennessee Department of Human Services for input and consultation from the Program Director for Adult Protective Services, State Office.

3. The conclusions or reports which result from the data supplied by our department will be presented in a cumulative style and will fully protect the identity of any individual recipient of Adult Protective Services. County reports will not be presented for counties with less than 10 open cases.

4. We agree with your plans to use this research in completing your dissertation for your doctoral degree at the University of Tennessee. It is understood that appropriate recognition will be given to the Tennessee Department of Human Services and that before the results are formally released, they will be shared with the Tennessee Department of Human Services for our use in fulfilling our responsibility under the law.

Your interest in the field of adult abuse and neglect is appreciated. We look forward to receiving the results of your work on this topic.

Your signature on this letter is considered your acceptance of the conditions which have been stated.

Sincerely,

Rachel Touchton
Assistant Commissioner

RT:MW:rt

Agreed to this date:

_____
Paul Villas

_____
Date

Disc format requested:
ASCII ____ or DBase _____

HARVARD MEDICAL SCHOOL



Geriatric Education Center

Benjamin Liptzin, M.D., Director
Terry Fulmer, R.N., Ph.D., Associate Director
Sue Levkoff, Sc.D., Associate Director
Terrie Wetle, Ph.D., Associate Director

643 Huntington Avenue
Boston, Massachusetts 02115
(617) 732-1463

We are pleased to send you the attached material...

Per your request ✓

Per our conversation

For your information

FROM: Jerry

Good luck + I'll look forward to your progress!

APPENDIX E

HARVARD MEDICAL SCHOOL

VITA

Paul Villas was born in Soham, New Mexico, on July 31, 1948. He attended Soham Elementary School and Pecos High School, graduating in May, 1966. In the fall of 1966, he entered the College of Santa Fe, Santa Fe, New Mexico, from which he received a Bachelor of Arts degree in Physical Education in May, 1970.

After three years as a teacher and coach, he enrolled in the master's program at the University of Southern Mississippi in the fall of 1973. He finished that program in August, 1974, and was awarded a Master of Science degree in Health Education. He then served as administrator of two Christian schools in Georgia until his appointment as assistant professor in the Health and Physical Education Department at Tennessee Temple University, Chattanooga, Tennessee, in the fall of 1983.

In the summer of 1986, he enrolled at the University of Tennessee in Knoxville, Tennessee, to begin work on the Doctor of Education degree. He received the Doctor of Education degree with a major in Health Education and a split collateral in Public Health and Physical Education in June, 1988.